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A Qualitative Analysis
of the Epiphany Experiences
of Chemically Dependent Women in Recovery

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A Qualitative Analysis
of the Epiphany Experiences
# of Chemically Dependent Women in Recovery

by

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Dedication

I dedicate this manuscript first to God, for without God's Grace, none of this would have been possible.

To my parents, Richard and Nancy Stokely, who gave me life, love, support and hope…when I had none.

To my wonderful children, Joshua and Jessica Woodruff, who are my joy and my inspiration.

To Robert S, who gave me passion…and who taught me to live life out loud, and to take time for the people that you love… every day... Keep Heaven Entertained…I may be awhile…

And, to the great spirits of these courageous women who were so willing to share themselves….I love, admire, and respect each one of you.

This poem on the following pages was written by one of the women that so graciously volunteered to share a part of her life with me…and with you. It describes the addiction and recovery process detailed in this manuscript.

Unity

Deep, deep down in my bowels
Is a tiny capsule
That contains my selfness.
All these years I have
Hidden it
        Protected it
                Disconnected it.
But still it remained
Unformed and primitive
Yet vital and tenacious.
I put it there so long ago
And it awaited me
Like Sleeping Beauty waited for her Prince.

It has tremendous density.
For in it is compressed:
        My capacity for joy,
        My reason for being,
        My source of courage and power
Was it accident or design?
I know not,
But one day not long ago I remembered
Where my true self was.
I wept bitter tears of futile regret
Because I had hidden my essence
Even from myself.

When I was finished crying

I was frantic.
Wildly impatient,
I began to tear away the layers
Of masks and disguises
Which I had fashioned and donned
To protect this precious capsule.
I found the masks and pretences
Were not layered
But intertwined
And enmeshed
In a confusing maze.

Just as I was ready to admit defeat
The capsule within
Began to expand and grow
For a fleeting moment joy escaped
And unerringly wound its way out of the labyrinth
Next came courage,
Then power.
Still traveling a roundabout course
But traveling nevertheless…

The capsule was no longer comfy
In its long-time home.
It, too, became impatient to be free.
Inwardly and outwardly, war was waged.
On masks and lies and Walls of doubt and fear;
So that at last my will to be
And my capacity to be
Junctioned and joined and I became whole.

Thank you

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I would like to thank the women, who were so gracious and open with the innermost parts of themselves with the hope that their stories would benefit others.

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Preface

This manuscript contains stories about the lived experiences of women and their life's journey through childhood, alcoholism, drug addiction, abstinence, recovery, and life. Therefore, this manuscript is also about mental health, discrimination, alcoholism, addiction, desperation, hopelessness, survival, peace, contentment, transcendence and humor.

I have traveled a similar path; many of my personal experiences resound through the voices and stories of these women. I was personally introduced to a variety of approaches designed to "treat" alcoholism and other chemical dependencies that were employed by many private treatment facilities in the early 1980's. Although diagnosed with alcoholism, I also retained other, less desirable problems - decidedly beyond their scope of treatment. Namely, these consisted of age (>25 years of age), female, and addicted to drugs other than alcohol, and was "prone to fits of rage and anti-social behavior." Therefore, I was not an appropriate candidate. In addition, cost of treatment was excluded from insurance coverage due to treatment for drugs other than alcohol.

I was fortunate enough to have been introduced to a small group of recovering addicts who had found a way to live without the use of drugs; and who were willing to share their experience, strength and hope. It was the very few women in this group who were brave enough and who cared enough to show me the truth about myself. Through

trial and error we discovered for ourselves what worked and what did not. And it didn't cost a dime.

Although the advancements through scientific research have contributed greatly to the growing body of knowledge in the area of substance abuse in general, and also has provided information to develop better treatment strategies, there still remains much to be discovered.

My area of specialization is Health Education. My primary area of interest is substance abuse, with emphasis on women's health, especially as it relates to women and addiction.

In the past 16 years, I have heard the stories of hundreds of other recovering women. The similarities are astounding. I believe much insight can be gained from the experiences of these women who have lived, struggled, and survived their own difficulties with addiction and who have found happiness, contentment, as well as meaning and purpose in life. Many of these women believe - not in spite of, but because of - that their transcendence through difficulty provided them a path to spiritual enlightenment.

A Qualitative Analysis
Of the Epiphany Experiences
Of Chemically Dependent Women in Recovery

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Alcoholism and drug addiction are among the most significant concerns of our nation today. The families of the addict are helpless and perplexed by the seemingly unexplainable, often bizarre, and self-destructive behavior which so often physically, mentally, emotionally, and financially destroys the lives of those afflicted with this grave disorder.

Our society has traditionally viewed alcoholism and substance abuse as disorders that predominantly affect men, even though statistics suggest otherwise. The purpose of this study was to document common themes of the addiction and recovery process

among women recovering within the framework of a 12-step fellowship related to alcoholism and other drug abuse problems.

Naturalistic, or qualitative inquiry, and interpretive interactionism was considered to be the most appropriate method for this study. Interpretive interactionism specified the method of qualitative inquiry, while the feminist theory informed the framework for the study. Data were collected through life history interviews with women who were self-proclaimed addicts and/or alcoholics who had been clean and sober between 5 and 22 years, and who participated in one or more 12-step programs.

Five themes emerged from the data. Theme I, caught in vicious cycles, refers to the abuse and/or violence, mental illness or addiction exhibited first by the participants' parent(s), and then later by the participants, and their efforts to conceal this aberrant behavior from the outside world. Theme II indicates what the women endured and how they adapted to the environment in order to survive. Theme III characterizes what happened to the participants as their worlds began to crumble. Theme IV encompasses the initial stages of learning about a new way to live. Theme V embodies the process of becoming whole. This process includes the importance of finding other individuals who had found a different way to live without the use of alcohol or other drugs. This process also includes the importance of finding other women, in particular, who seemed to provide the women with a level of identification that ran deeper than just recovering from chemical dependency. The process of becoming whole also includes transforming moments or events that occurred in the lives of the participants that helped them develop

faith and overcome seemingly impossible obstacles. The culmination of this theme was the synergy that occurred as a result of the women putting the pieces of their shattered lives back together, to form a whole person, much greater than the sum of the parts.

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CHAPTER 1: INTRODUCTORY OVERVIEW

Introduction

Alcoholism and drug addiction are among the most significant concerns of our nation today. The cost of fighting the war on drugs in America has surpassed the trillion-dollar mark, and yet, the consequences related to substance abuse continue to affect millions of Americans on a daily basis. A study released in 1998 by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated the economic cost of alcohol and drug abuse to be $245.7 billion for 1992, the most recent year for which sufficient data were available. Alcohol abuse and alcoholism accounted for about 60% of the estimated cost with the remaining 40% attributed to drug abuse (NIDA & NIAAA, 1998).

Drug abuse has serious health-related consequences for the individual, as well as for their families and related communities. The families of the addict are helpless and perplexed by the seemingly unexplainable, often bizarre, and self-destructive behavior which so often physically, mentally, emotionally, and financially destroys the lives of those afflicted with this grave disorder. In 1999, an estimated 14.8 million Americans were considered current (at least one use in the last 30 days) users of illicit drugs, while almost 2% of the total population of Americans ages 12 and over, were considered dependent on illegal substances. Age-adjusted death rates for drug-induced causes

increased 64 percent between 1990 and 1998; 32% of these deaths were women [Substance Abuse and Mental Health Services Administration (SAMHSA), 2000].

In addition to other drug abuse problems, alcoholism also has devastating health-related consequences. SAMHSA (2000) reported chronic liver disease and cirrhosis to be the 10th leading cause of death in the United States (U.S.) in 1999 (National Center for Health Statistics, 2000). Also in 1999, 105 million people age 12 and older reported current use of alcohol (SAMHSA, 2000). Forty-one percent of individuals reporting alcohol use were female; and although underage drinking is illegal, in the youngest age bracket (12-17), males (19.2%) and females (18.1%) had comparable rates of current (at least one use in the last 30 days) alcohol use. Among women in the general population, the highest prevalence rates for both alcohol dependence and abuse were found among women of childbearing years. In addition, of the 3.6 million Americans who were dependent on illicit drugs, 1.5 million were dependent on *both* alcohol and other drugs (SAMHSA, 2000). These numbers indicate that alcohol and drug abuse problems continue to undermine the health, happiness, and well-being of individuals of all ages, their families, as well as society as a whole, despite staggering economic and health-related consequences.

Background and Significance

The devastating consequences associated with behaviors stemming from alcohol and other drug addictions impose tragedy on other members of society, often leading to outrage and condemnation of the chemically dependent individual. The emotional

upheaval of the general public, although justified, has served to link addiction with criminal prosecution of offenders and does little to promote understanding of the underlying problem(s). On the other hand, increased public awareness has led to an increase in funding for research to discover solutions to help prevent and eliminate addiction and related problems.

Our society has traditionally viewed alcoholism and substance abuse as disorders that predominantly affect men, even though statistics suggest otherwise. Nevertheless, the vast majority of initial research designed to investigate the general nature, prevention and treatment of alcohol and other drug abuse problems focused almost exclusively on the male-addicted population. Prior to 1980, fewer than 10 studies that included women were reported in the treatment literature (Blumenthal, 1994). It was this research that established the knowledge base used to inform the procedural development of strategies intended to identify, diagnose, and treat chemical dependency disorders.

Generally speaking, and for the purposes of the present study, treatment and recovery are not synonymous. Usually, professionals (and clients) in the addiction field utilize the term "treatment" as an abbreviation referring to a chemical dependency "treatment center." For example, if someone says, "I think I need treatment," they most often mean they need to check into a treatment facility, very similar to a hospital or other institutionalized setting. In the current study, treatment refers to techniques, strategies, or methods that serve as avenues to recovery, predominantly through rehabilitation facilities and the methods incorporated and adopted by a particular service facility. This

type of treatment includes in-patient and/or out-patient, may be long-term, short-term or a combination of both. Recovery, on the other hand, is a process whereby tools and living skills are learned and adapted to help support healing lifestyle changes. A more detailed explanation may be found in the "Description and Clarification of Terms" section at the end of this chapter.

Consequential physiological differences, as well as gender differences produced by the socialization process, have limited women's ability to seek, access, and obtain treatment for chemical dependency. As previously mentioned, most treatment programs originally were developed specifically for men. The strategies and techniques used to address issues in the recovery process were not salient for many female clients as they began seeking help for chemical dependency problems. When unsatisfactory progress was made with standard treatment practices, rather than scrutinize traditional therapy procedures, the female client was often labeled as "resistant to treatment" or as having an "addictive personality disorder" (Root, 1989). The following paragraphs of this section highlight several of the differences between chemically dependent men and women, the effects of those differences on accessing treatment services, and their efficacy in serving the chemically dependent female population.

Morality issues have led to hypocritical biases surrounding drug use in American society by women in general, but particularly in the ascribed role of motherhood. Beginning in the early '70s, the primary focus of studies that included women were designed to investigate the impact of addiction on the family, children, and the fetus

(Blumenthal, 1994), which reflects the traditional view of women in their role defined by society based on biological, child-bearing functions. Marsh, Colten, and Tucker (1982) found the most frequently expressed theme in the literature regarding substance use among women (which was reflected in resource allocation for treatment and research) was related to the well-being of the children of substance abusing women. Rather than investigate solutions for the chemically dependent mother, the literature suggests that substance-abusing women have been the target of anger and blame, and that continuing neglect of this issue has led to a lack of treatment services for these special populations of women with children (Finklestein, 1994).

Limited treatment services and persecution by the general public combined with other traditional gender role socialization heavily influence interpersonal and social barriers to treatment that are specific to women. The most common barriers for not obtaining treatment have been divided into internal and external categories. External barriers include opposition from family and friends, social and economic cost, inadequate training of health professionals, lack of women-sensitive treatment services, differential referral patterns, lack of or inadequate insurance coverage, and lack of child care facilities (Beckman, 1994; Nelson-Zlupko, Kauffman, & Dore, 1995). Baker (2000) found women frequently lacked access to treatment due to gender-related, societal-imposed disparities such as child-care concerns. Women are reported to have less education, make less money, are less likely to have health insurance, and have fewer life options (Nelson-Zlupko et al., 1995).

Internal barriers found to be associated with lack of treatment-seeking behavior were denial of a drinking problem, fear of stigmatization, guilt, shame, and concern of leaving or losing dependent children (Beckman, 1994). In addition, alcohol dependency is reported to have impacted their lives more severely than men's lives, causing greater disruption (Nelson-Zlupko et al., 1995). Therefore, lack of women-sensitive treatment services, opposition from family and friends, and fear of violent reprisal by domestic partners stack incredible odds against chemically dependent women (Root, 1989).

Many of the women who do seek treatment for chemical dependency report histories of violence, sexual abuse, and physical abuse (Kang, Magura, Laudet, & Whitney, 1999; Jarvis, Copeland, & Walton, 1998; Spak, Spak, & Allebeck, 1998; Chiavaroli, 1992; Goulding & Schwartz, 1995; Schwartz, 1995). Currently, researchers argue that effective treatment for these women must simultaneously address issues of gender-specific victimization in addition to chemical dependency, since many women may utilize substance abuse as a mechanism for coping with trauma (Kang et al., 1999; Chiavaroli, 1992).

More attention and funding are currently being devoted to examine the problems associated with women and addiction than ever before, especially as the number of women who use alcohol and/or other drugs during pregnancy continues to rise. There are now programs, though very limited, that have been designed to address the difficulties and the needs unique to chemically dependent pregnant women (Paone, Chavkin, Willets, Friedman, & Des Jarlais, 1992). There are also programs designed to

address at least some of the problems encountered by women (especially single women) who have children (Marsh, D'Aunno, & Smith, 2000).

Although progress is being made, as indicated by increasing numbers of researchers who have begun to focus on the experiences of chemically dependent women from within the context of their personal history, most studies that have inquired and related these life-events are limited to clients currently in, or recently discharged from treatment facilities (Baker, 2000; Salmon, Joseph, Saylor, & Mann, 2000; Burman, 1993). Information gained from women in treatment provides necessary and valuable insight into the problems associated with chemical dependency and women. This information does little, though, to identify or address problems unique to women who lack access to treatment, nor does it illuminate effective long-term recovery strategies.

Hunt and Seeman (1990) investigated the process of women's recovery through a comparative analysis of interviews conducted with 15 women in treatment for alcoholism and 15 women with long-term sobriety. They found despair and loneliness to be central themes in the interviews of the women in the treatment group, while women in the second group reflected relationships as central to the major reconstruction of their lives. Further investigation is needed to determine if generalizations from this study associated with alcoholism are similar to the problems experienced by women who abuse other addictive drugs.

Lowery (1998) examined recovering women's personal stories of the addiction and recovery process. The original study is an unpublished doctoral dissertation based

on the experiences of six American Indian women who had been clean and sober for two years (Lowery, 1994). The information gathered in this study was then developed into a qualitative model of long-term recovery for American Indian women based on their cultural history and spiritual beliefs (Lowery, 1999). This analysis illustrates how the difficulties of the individual are inextricably linked with their surrounding circumstances.

It would seem prudent to continue to explore the personal experiences of similar problems and the meanings ascribed to them by women in various cultures, rather than from the viewpoint of the society that defines them. The significant absence of this type of information indicates serious gaps in understanding the problems encountered and surmounted by recovering women, and the importance of further investigation detailing women's subjective experiences of the addiction and recovery process.

The current study was designed to explore the experiences of chemically dependent Caucasian women who have been clean and sober for at least 5 consecutive years. Hopefully, the strategies employed by these women to personally overcome the barriers associated with their substance abuse during the addiction and recovery process will lead to more insightful policy development and treatment programming for chemically dependent women.

Purpose of the Study

The purpose of this study was to document common themes of the addiction and recovery process among women recovering within the framework of a 12-step fellowship related to alcoholism and other drug abuse problems.

Research Question

Within this context, the research question was, "How do women who have relied on the framework of 12-step programs personally experience the addiction and the recovery process?" Data were collected through life history interviews with women who were self-proclaimed addicts and/or alcoholics and who were abstinent for at least 5 consecutive years. (Refer to Appendices A and B for copies of the original and modified versions of the interview guide, respectively).

All women attended 12-step meetings; however, their experiences with formal "treatment" varied (for further discussion see Chapter 4). This information was evaluated through the interpretive criteria set forth by Denzin (1989) in an effort to establish guidelines for developing more effective treatment strategies for women. Interpretive interactionism incorporates the theoretical framework based on feminist theory as a vital part of the interpretive process. Campbell and Bunting (1991) categorize feminist theory as a world-view or frame of reference in which the vantage point of a particular group of women's experiences are the focus of investigation with an activistic purpose of improving conditions for women and all persons, individually and

collectively. Feminist theory recognizes that knowledge is socially and historically constructed and respects contextual subjective perceptions, experiences and feelings as valuable information (Campbell & Bunting, 1991).

Interpretive interactionism is a naturalistic approach to social research, which endeavors to make the world of lived experience directly available to the reader. It relies on thick description, which vividly details the participants' experiences and captures the nuances that influence their perception, interpretation, and therefore, the meanings they give to those experiences, or epiphanies, that so fundamentally, completely and totally mold their lives. The focus of interpretive investigation is on those life experiences that radically change and shape the meanings persons give to themselves and their life projects (Denzin, 1989).

Interpretive interactionism seeks to identify relationships that exist between a problem defined by society, such as drug abuse, and the programs designed to alleviate or solve the "problem," such as the national "war" declared on drugs, and therefore on the individuals who are addicted to them. Most often the individual's personal experiences of addiction and recovery from within the culture are largely ignored. Denzin (1989) states, "the perspectives and experiences of those persons who are served by applied programs must be grasped, interpreted, and understood if solid, effective, applied programs are to be created" (p. 12).

Underlying Assumptions of the Study

Seven major assumptions underlie this study:

1. Women can act as self-observers and communicate valid data about their experiences;
2. Women who indicate that they have experienced the addiction and recovery process can identify elements of the phenomenon and tell other persons about their experiences;
3. The interpretive interactionistic approach focuses on the women's experiences and is an appropriate methodology for the complex context of the experiences;
4. Phenomena, such as pain, fear, hopelessness, power, and faith are often used to describe the addiction and recovery process, and are all legitimate human experiences;
5. People are inseparable from their experiences in the physical world;
6. Electronically recorded responses are an accurate as well as a reliable medium to preserve a person's words when describing an experience; and
7. Electronic recordings are appropriate working tools for the researcher to identify common themes or categories of responses.

Limitations of the Study

There are three major limitations of this study. First, interpretive interactionism is designed to convey the personal meaning of the participant's lived experience. While techniques for establishing trustworthiness (i.e., research team and member checks) were utilized to help ensure that the participant's (and not the researcher's) meaning was conveyed to the reader, the possibility always exists that imprecise translations occurred

in the interpretive process. Second, the findings of the study cannot be generalized beyond the sample, due to the small sample size and the criteria used for sample selection. It should be noted that sample selection was limited to women who had participated in a 12-step recovery program(s) and who had been clean and sober for at least 5 years. The issue of generalizability is addressed in Chapter 3 from the perspective of qualitative research. Third, the themes and categories of the addiction and recovery processes discovered through this research procedure may be aberrant, because they are based upon subjective experiences that have been subjectively interpreted by the participant, the researcher, and the analysis team.

Conclusion

In studies of concepts that lack universal definition, such as the study of the addiction and recovery process, where there is difficulty in distinguishing one definition or process from another, the interpretive interactionistic research approach is appropriate (Chiu, 1996). Interpretive interactionism is an exploratory method designed to explain the world of experience and to help clarify its important phenomena. Personal experiences, when viewed from within cultural and social contexts, often present a different interpretation of traditionally defined problems. The impact of environmental variables mediated by individual genetic and personality differences create synergistic effects when viewed in conjunction with one another, leading to an alternate definition of the problem, and therefore, possibly to alternate solutions(s) as well. Due to the limitations of this study, its findings are intended to describe only the experience of the

addiction and recovery process from the perspective of a group of 12-step oriented, chemically dependent Caucasian women who have been clean and sober for at least five years.

Clarification of Terms

The following list of terms contains definitions of words specific to naturalistic inquiry, as well as clarification of particular expressions as they relate to addiction and recovery in this study. For the purposes of the current study, these meanings are primarily derived from a 12-step oriented [Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA)] perspective as interpreted by the researcher. For a more in-depth description of AA and NA 12-step programs, refer to Appendices C and D, respectively.

The terms "clean" and "sober" refer to an individual's physical abstinence from alcohol and/or other psychoactive drugs, with an additional component of mental well-being; "dry" or "abstinent" refers simply to the physical state of abstinence. For example, the term "clean" or "sober" refers to an individual who has found some semblance of internal relief and contentment in his or her life through active participation in recovery while maintaining abstinence; whereas, "dry" or "abstinent" refers to an individual who is merely not actively ingesting alcohol or other addictive drugs. Another commonly used term (among members in 12-step fellowships) is "slip." Occasionally, a man or woman, who has been clean and sober will drink or use other

drugs again. In 12-step programs, a relapse of this type is commonly known as a "slip." It may occur during the first few weeks or months of abstinence or after a number of years.

An important delineation between the terms “treatment” and “recovery” is necessary to promote contextual understanding in the interpretation of this inquiry. “Treatment” refers to short-term (approximately 30 days or less) and/or long-term (generally ranges from 2-24 months) participation, in either in-patient (i.e., 24-hours a day, seven days a week) and/or out-patient (i.e., attend classes or programs at specified times and places) treatment offered by drug and alcohol rehabilitation facilities. Treatment is considered finite; it has a definitive beginning and ending. Alternatively, recovery is an ongoing process of personal growth and development. For the purpose of this study, treatment and 12-step programs are viewed as avenues to recovery, rather than recovery itself.

Now we enter the gray and controversial area regarding the use and definition of the terms “alcoholic” and “addict.” An alcoholic is an individual whose dependence is limited to alcohol. An addict is an individual who may be dependent on alcohol, other addictive drugs, or both. Although (technically speaking) an alcoholic is considered an addict, individuals identify themselves as alcoholics in meetings of AA, and as addicts in meetings of NA In this manner, each fellowship can better serve its past, present, and future members without diluting the focus, purpose, or message of recovery.

Definition of Terms

abstinent/abstinence: refers to an individual who is simply not actively ingesting alcohol or other addictive drugs (as opposed to "clean" or "sober/sobriety").

abuse: physical, sexual, verbal, emotional, and/or psychological maltreatment directed specifically at the participant(s) in the current study.

addiction: persistent compulsive use of a substance known by the user to be harmful (Merriam-Webster's Collegiate Dictionary, 1998).

addict: an individual who may be dependent on alcohol, other addictive drugs, or both.

alcohol abuse: refers to patterns of problem drinking that result in health consequences, social problems, or both (NIAAA, 1990).

alcohol dependence: often called alcoholism, refers to a disease that is characterized by abnormal alcohol-seeking behavior that leads to impaired control over drinking [Department of Health and Human Services (DHHS), 1993].

alcoholic: an individual whose dependence is limited to alcohol.

alcoholism: a complex chronic psychological and nutritional disorder associated with excessive and usually compulsive drinking (Merriam-Webster's Collegiate Dictionary, 1998).

audit trail: analogous to fiscal audit; audit of research documentation in order to establish if logical decisions were made in the interpretation process (Lincoln & Guba, 1985).

bracketing: isolating the key, essential features of the processes under inspection (Denzin, 1989).

capture: securing instances of the phenomenon being studied (Denzin, 1989); In other words, obtaining several examples of the experiences that are the focus of the investigation.

categorical saturation: the point in data analysis and collection in which no new categories are added and within which themes consistently recur (Parse, 1990).

chemical dependency: refers to abnormal alcohol and/or other drug-seeking behavior that leads to impaired control over drinking or other drug use.

clean: refers to an individual's physical abstinence from alcohol and/or other psychoactive drugs, with an additional component of mental well-being; an individual who has found some semblance of internal relief and contentment in their life through active participation in recovery while maintaining abstinence.

confirmability: extent to which data are publicly notated and interpretations are grounded in the data (Greene, Dougherty, Marquart, Ray, & Roberts, 1988).

construction: follows bracketing, involves putting the key elements of a phenomenon back together again, in temporal order; leads to contextualizing (Denzin, 1989).

contextualizing: relocating bracketed phenomenon back in the worlds of lived experience (Denzin, 1989).

credibility: consistency of results and interpretations with important audiences within that context (parallels internal validity) (Greene et al., 1988).

deconstruction: critical analysis and interpretation of prior studies and representations of the phenomenon in question (Denzin, 1989).

dependability: soundness, competence, and professional quality of the methods used (parallels reliability) (Greene et al., 1988).

domestic violence: aggressive and abusive behavior between partners, spouses, or "significant others" and/or the family as a group.

dry: refers to an individual who is simply abstinent (not actively ingesting alcohol or other addictive drugs) as opposed to "clean" or "sober/sobriety."

epiphany: moment of problematic experience that illuminates personal character, and often signifies a turning point in a person's life; types - major, minor, illuminative, relived (Denzin, 1989).

ethnography: the study of a culture (Aamodt, 1982).

interaction: to act on one another, to be capable of mutual action that is emergent. For human beings, interaction is symbolic, involving the use of language. Hence the term "symbolic interaction" (Denzin, 1989).

interpretive interactionism: qualitative research method which attempts to reveal the world of transformational experiences which shape the meanings persons give to themselves and their life projects (Denzin, 1989).

lived experience: the world of life experiences and the meanings ascribed to them by the individual (Denzin, 1989).

member checks: method whereby data, analytic categories, interpretations, and conclusions are tested with members of the stakeholding group from whom the data were originally collected (crucial technique for establishing credibility) (Lincoln & Guba, 1985).

oppression: unjust or cruel exercise of power over another (Merriam-Webster's Collegiate Dictionary, 1998).

personal experience story: "a narrative that relates the self of the teller to a significant set of personal experiences that have already occurred" (Denzin, 1989, p. 38).

problematic interaction: interactional sequences that give primary meaning to the subject's life. Such experiences alter how persons define themselves, and their relations with others. In these moments, persons reveal personal character (Denzin, 1989).

recovery: remission of alcoholism and/or chemical dependency that occurs as a result of an addict and/or alcoholic internally and actively participating in a personal program that allows the individual to gain insight, fulfillment, and personal growth toward becoming a responsible, productive member of society.

redundancy: refers to the depth of categorical saturation; point in which no new information is provided within a category when further interviews and analyses are performed (Parse, 1990).

self-defined addict: individual perspective of personal drug use.

self-story: "a narrative that creates and interprets a structure of experience as it is being told" (Denzin, 1989, p. 38).

slip: commonly referred to as a relapse; the return to alcohol or other drug use after a period of abstinence.

snowball sampling: process of subject selection based on referrals from the original subjects (Patton, 1990).

sober/sobriety: refer to an individual's physical abstinence from alcohol with an additional component of mental well-being; an individual who has found some semblance of internal relief and contentment in their life through active participation in recovery while maintaining abstinence.

sophisticated rigor: a commitment to make one's interpretive materials and methods as public as possible (Lincoln & Guba, 1985).

theoretical or purposive sampling: process of subject selection based on some a priori criterion of interest (Lincoln & Guba, 1985).

thick description: an appropriate information base that relates everything a reader may need to know in order to understand the findings (Lincoln & Guba, 1985).

transferability (or applicability): fittingness of results and interpretations to audiences in other contexts (parallels external validity) (Greene et al., 1988).

treatment: refers to a structured program, either short-term (approximately 30 days or less) and/or long-term (2-24 months) and, either in-patient (i.e., 24-hours a day, seven days a week) and/or out patient (i.e., attend classes or programs at specified

times and places) participation of chemically dependent individuals specifically related to drug and alcohol rehabilitation facilities.

triangulation: multiple data sources or multiple thick description narratives (Lincoln & Guba; 1985).

trustworthiness: the fundamental concept for establishing correlates of reliability and validity in qualitative research (Lincoln & Guba, 1985).

CHAPTER 2: RELATED LITERATURE

Introduction

The World Health Organization (WHO) defines health as not just the absence of disease and infirmity but complete physical, mental and social well-being (WHO, 1978). Many medical anthropologists regard health to be a cultural construction whose meaning varies from one society or historical period to another (Baer, Singer, & Susser, 1997). Currently, there is little doubt that addiction to alcohol and other drugs compromises the health and quality (and in many instances the quantity) of life for millions of men, women, and children on a daily basis - not only in this country, but in other parts of the world as well.

Many theories posit the etiology and development of addiction to alcohol and other drugs. Addictive behaviors have created a set of complex social problems that have become a major focal point in our political, legislative, and criminal justice systems, as well as in the medical and research communities. Our society tends to place responsibility for addiction solely upon the chemically dependent individual. The information presented in this chapter takes the narrow focus that has typically been placed on the individual and expands it to encompass the social, cultural, environmental, political, historical, and economic circumstances surrounding any culturally defined "problem."

If true change is to take place, we must understand the underlying power structures that maintain inequality and how they impact the personal world of the female addict. There are women who have experienced violence and abuse, alcoholism and chemical dependency; and yet, have emerged - against all odds - as strong and independent women. I believe these women hold the key in helping us better understand the factors involved in creating and sustaining this health condition.

The present study was developed to ascertain first-hand accounts from women regarding their lived-experiences with addiction and recovery. The experiences of these women provide insight for identifying fundamental intervention points necessary to facilitate the environmental, political and social changes conducive to the prevention and treatment of chemical dependency. This chapter describes the social, economic, historical, political, and legal arrangements that weave the social context of addiction that influences the perspectives that have insidiously become integrated into the beliefs of everyday, ordinary people.

The theoretical framework applied in the current study is based on feminist theory. Feminist theory is a method used to critically evaluate the historical, social, and political construction of gender and gender disparities. In this chapter, feminist theory is utilized to examine how these inequalities were created by “the powers that be” and their role in the social construction and historical development of women’s addiction and treatment in the U.S.

The significance of alcoholism and other drug abuse problems are discussed in separate sections. The division between alcohol and other drugs of abuse is based on legal and political distinctions that affect research funding and publication. For the purpose of the present study, all drugs are considered to have equal status when the use of the substance becomes problematic for the individual. However, much of the literature designed to examine the effects of drug use, abuse, and dependence is limited primarily to the study of alcohol. Legislative policy dictates available research funding, producing disparities that arise from ethical concerns referencing licit and (especially) illicit drug use involving human subjects. Therefore, the divisions in the following discussion, though arbitrary, are necessitated by these regulatory practices.

ALCOHOL USE, ABUSE, AND DEPENDENCE IN THE U.S.

Alcohol is the most widely used drug in the world (Baer et al., 1997). Alcohol use disorders are estimated to affect in excess of 10% of the U.S. population (Conners, 1995). According to the NIAAA, alcohol *abuse* refers to patterns of problem drinking that result in health consequences, social problems, or both. Alcohol *dependence*, often called alcoholism, refers to a disease that is characterized by abnormal alcohol-seeking behavior that leads to impaired control over drinking (DHHS, 1993).

In 1990, the NIAAA estimated female alcohol *abuse* in the general U.S. population to be roughly *one-third* of the *total* alcohol-*abusing* or alcohol-*dependent* population (NIAAA, 1990). Although past research in prevalence rates has indicated a larger number of men than women *drink* (Wilsnack, Wilsnack, & Hiller-Sturmhofel,

1994), the gap may be narrowing. Statistics reported by SAMHSA (2000) found 41% of individuals reporting alcohol *use* were female. In 1993, DHHS reported that individuals between the ages of 18 and 29 exhibited approximately *equal* prevalence rates for male and female alcohol *abuse* or *dependence*, with the gender gap widening with increasing age (DHHS, 1993). SAMHSA's findings released in 2000 indicated that even though underage drinking is illegal, reported rates of current alcohol *use* were *comparable* in the youngest age bracket (12-17), for males (19.2%) and females (18.1%) (SAMHSA, 2000). Several competing theories are plausible; either 1) alcohol use among females is increasing, 2) a greater number of women than men quit drinking, or 3) women who drink develop more severe alcohol-related problems than men who drink and die at an earlier age (which is supported in the following section), and would account for the unequal prevalence rates of dependence between men and women in increasing age brackets. Regardless, current economic and health consequences associated with alcohol use will undoubtedly escalate if these trends continue.

There are devastating economic and health consequences associated with alcohol abuse and dependence. The economic impact of alcohol dependence (alcoholism) or alcohol-related consequences alone is astronomical. This figure was estimated to be almost $86 billion as the 1980's came to a close. These figures include treatment, medical expenses, productivity losses, and estimated years of life lost due to premature morbidity and mortality (DHHS, 1993). This figure increased by 100% in just two years. By 1992, these costs had risen to $148 billion annually (NIDA & NIAAA, 1998).

Alcohol-related mortality accounted for about 5% of all deaths in the U.S. in 1988 (NIAAA, 1990). Deaths due to alcohol-related automotive collisions contribute significantly to estimated mortality rates. In 1994, there were 16,600 alcohol-related motor vehicle fatalities. Approximately 5,500 of these deaths were persons 25 years of age or younger (Morbidity and Mortality Weekly Report, 1995). Another significant factor that contributes to alcohol-related mortality is cirrhosis. Cirrhosis of the liver is a primary health condition found to be associated with alcohol abuse or dependence, which causes death, as well as disease. Data extrapolated from DHHS (1993) and SAMHSA (2000) indicate that, in the U S., cirrhosis has ranked as one of the leading causes of death for the past 15 years.

Cirrhosis disproportionately affects women who drink. In 1998, the National Center on Addiction and Substance Abuse (NCASA) reported that 1.8 million women over the age of 59 abused, or were addicted, to alcohol (NCASA, 1998). Mature women (age 60 and over) who drink are more likely than men to develop cirrhosis, to develop it sooner, and from consuming smaller amounts of alcohol (NCASA, 1998). Intoxication effects of alcohol are greater in women at lower levels of consumption, due to absorption differences in first pass metabolism. Liver damage is also more severe in female alcoholics resulting in greater rates of fatalities from alcohol-induced cirrhosis. As a result of differences in metabolism and body fat composition, women maintain higher blood-alcohol levels than men. This contributes to more severe and accelerated liver injury; hence, mortality rates for all cases of cirrhosis are 50% higher in women (Lieber,

1993). In the last two decades, researchers have uncovered gender-specific distinctions that create a fatal combination of drug use patterns and physiological differences that contribute to the death rate of female alcoholics, which is 50 to 100 times greater than male alcoholics (Nelson-Zlupko et al., 1995; Lex, 1994; NIAAA, 1990; Blume, 1989; Hill, 1982). In addition to the debilitating health conditions sustained from alcohol-related problems, the consequences associated with the use and/or abuse of, or dependence on, other licit or illicit drugs are equally as devastating.

OTHER DRUG USE, ABUSE, AND DEPENDENCE IN THE U.S.

Problems with abuse and/or dependence on drugs (other than alcohol) also contribute significantly to devastating health and social consequences, which add to rising economic costs. Based on data collected in 1992, NIDA and the NIAAA (1998) estimated the economic cost of drug abuse (other than alcohol) to be $97.7 billion annually. These costs include morbidity and premature mortality in the U.S. (National Center for Health Statistics, 1994). Just as women who drink are more susceptible to the deleterious effects of alcohol, women who use drugs other than alcohol are also at greater risk than men for developing chemically dependent-related problems.

Several studies have documented different patterns of drug use between chemically dependent men and women (Nelson-Zlupko et al., 1995; Blume, 1989; Gomberg, 1982). Women are more likely than men to be polysubstance abusers (i.e., abuse two or more drugs), to use in isolation, and to have limited social networks (Nelson-Zlupko et al., 1995). Female drug users tend to abuse licit (prescription) drugs,

while male clients generally use illegal, or "street," drugs. The NCASA (1998) states that 2.8 million women age 60 and over abuse or are addicted to psychoactive prescription (licit) drugs; women in this age group take, on the average, five prescriptions at a time. In 1996, 44.7% of individuals who reported using *illicit* drugs at least once in their lifetime were women, with 36.2% reporting use in the previous 30 days (SAMHSA, 1996).

Although men continue to outnumber women among the ranks of drug and alcohol abusers, statistics suggest that women's drug problems are not small and should not be taken lightly (McCollum & Trepper, 1995). Women are especially susceptible to the adverse effects of drug use. The age-adjusted death rate for drug-induced causes between 1990 and 1998 increased by 64%; of these deaths, 32% were women. The onset of usage for chemically dependent women is often characterized as sudden and heavy, as opposed to their male counterparts whose usage pattern is usually described as gradual and progressive. The onset of addiction tends to occur at an earlier age for men than women (Blume, 1989) but women become addicted more quickly, and the course of addiction progresses much more rapidly than in men. Women also experience a shorter time lapse between initial drug use and the onset of related problems, as well as incurring more severe physiological consequences at lower doses than their male counterparts (Hill, 1982). These physiological consequences have been determined to be associated with differential gender-specific physiologic composition and responses.

Therefore, women seem to experience a "telescoping" of dependence whereby they develop more serious physical and social problems while consuming lesser, or smaller amounts of the same substances over a shorter time period than their male counterparts (NIAAA, 1990). Physiological differences in increased fatty tissue and decreased body water composition result in a slower drug absorption rate and an increase in blood concentration levels which cause women to experience more adverse consequences (such as overdose) at lower doses and in shorter amounts of time than men (Piazza, Vrbka, & Yeager, 1989). These statistics provide substantial and significant documentation of the grave consequences of drug abuse and drug-related problems faced by all addicts, particularly those faced by chemically dependent women.

Compounding these difficulties are the attitudes expressed in U.S. society through Western medicine, which emphasize addiction and alcoholism as a problem at the level of the individual person (Baer et al., 1997), ignoring forces operating at the societal and even global levels. This viewpoint also ignores other factors, such as history and culture, that contribute to the way a society views, identifies and defines a problem by constructing the framework of perception, through which, the source and solution(s) of that problem are formulated.

Rudolph Virchow, a renowned German pathologist and a pioneer in social medicine, argued that the "material conditions of people's daily life at work, at home, and in the larger society constituted significant factors contributing to their diseases and ailments" (as cited by Baer et al., 1997, p. 36). Medical social scientists (and

particularly critical medical anthropologists) strive to identify the political, economic, social structural, and environmental conditions in all societies that contribute to the etiology of disease (Baer et al., 1997). It is through these avenues that substance abuse becomes a function of historical, political, and social factors (Marsh, 1982). Therefore, it becomes imperative to identify the way these public and social factors contribute to the cycle of addiction for individual women, so that effective strategies for change may be brought about.

Feminist Critique of the Probable Influences Contributing to the Development of the Addiction Process in Women

THE HISTORY OF WOMEN AND ADDICTION

Gomberg (1982) proposed that past and present political patterns influenced (and continue to influence) trends in the health care system that facilitate and mediate women's use of drugs. These include (for example) physiological events, biases in physicians' prescription practices, and the medicalization of women's health. Baer et al. (1997) convincingly argue that medicalization also contributes to increasing social control on the part of physicians and health institutions over behavior by serving to demystify and depoliticize the social origins of personal distress. Medicalization transforms a problem at the level of social structure - stressful work demands, unsafe working conditions, poverty, unemployment, underemployment, discrimination (race,

gender, etc.), violence, and abuse - into an individual problem under medical control. Paul (1978) further argues "medicine has from the beginning functioned in the service of imperialism, supporting logically the voracious search for ever wider markets and profitable deals" (p. 272). The role of physicians, pharmaceutical companies (including media involvement in pharmaceutical advertising), and pharmacists, as well as political and legislative actions, exemplify this proposition throughout the history of women and addiction.

The Effects of Medicine, Capitalism, Politics, and Legislation on Women's Development of Chemical Dependency

Early medical research established the male form and function as the accepted "standard" reference for evaluating health. Women's anatomy and physiology was viewed as a deviation from this standard, and therefore considered "abnormal," by the medical profession. The pharmaceutical and medical industry found the "treatment" of these abnormal female "conditions" around the turn of the century quite profitable. However, when the prescribed "treatment" caused injury and death, the women were quickly blamed, and thus held responsible for *their* lack of compliance and irresponsible behavior (Szalavitz, 1999).

Epidemiological data were not uniformly kept in the late 19th century in the U.S., but the existing (though limited) data that are available estimate that between 2/3 and 3/4 of the opiate addicts were women (Kandall, 1996). The factor that most significantly contributed to the large number of female addicts during this period was the prescribing

and dispensing practices of physicians and pharmacists. Cocaine, cannabis, and chloroform, as well as opiates, were regularly and liberally prescribed for "medical conditions" specific to women. These included the treatment of female reproductive problems (Marsh et al., 1982) such as painful intercourse, inflammation of the endometrium and urethra, dysmenorrhea, postpartum cervical lacerations, nausea associated with pregnancy, as well as neurasthenia, dyspepsia, hay fever, colds, and sinusitis. Physicians also supported the recreational and social use of these substances. Since the majority of these addicts were primarily upper class white women, with disproportionately high prevalence rates among nurses and physicians' wives, they were viewed as non-threatening; therefore, drug use within this context was widely accepted and tolerated (Kandall, 1996).

Around the turn of the century, there were several factors occurring simultaneously in American society that perpetuated an extreme shift in the nation's attitude toward drug use. As doctors and pharmacists became increasingly aware of the dangers posed by these drugs, acceptance and tolerance declined. Not only were doctors beginning to acknowledge the deaths of women associated with recreational or medicinal drug use, they were also beginning to see the effects of treating pregnant women with these drugs as the number of congenitally addicted infants increased. Since the mothers were held largely accountable for the care of their infants and children, they were being held increasingly responsible for the effects of the drugs they took during pregnancy or administered to their young children through legal patent medications (Szalavitz, 1999).

In short, women became addicted to the drugs prescribed by their doctors (which were also produced and heavily marketed by drug companies), who, upon discovering the adverse effects of these medications, relinquished themselves of responsibility by blaming the female mother/patient.

By the beginning of the 20th century, the nation had come to view drug addiction as counter to its best interests. This era also witnessed increasing numbers of Asian and African-American immigrants, who were perceived by politicians to be a threat to current capitalist society for generating domestic trade competition (Kandall, 1996). To gain support for repressive drug control laws, politicians recruited the motion picture industry to stereotype foreigners as dangerous and drug-crazed individuals who lured innocent women into prostitution and white slave trade through drug addiction (Szalavitz, 1999). Anti-drug legislation supporters manipulated the general public by sensationalizing the idea that foreign men were preying on white, middle-upper class American women by enticing them to take drugs, and then turning them into slavery and prostitution rings. So the plight of thousands of addicted women was used not as an issue to generate and obtain sympathetic treatment, but as an issue to sway voter opinion to pass repressive drug laws.

This politically motivated, anti-drug agenda established a connection between women, sexuality, and drug addiction that became (and remains) an important way to generate public outrage toward drug use by a population of users that was becoming increasingly minority, poor, and urban (Kandall, 1996). This equipped the politicians

with enough public persuasion to pass regulatory drug laws (to generate tax revenue), reducing the number of foreign business competitors with little regard for the well-being or fate of thousands of addicted women.

Anti-drug legislation was passed that began to regulate patent medications (Pure Food and Drug Act of 1906); limit and regulate the supply of narcotics to generate tax revenue (the Harrison Anti-Narcotics Act of 1914); and revoke physicians' rights to prescribe drugs for maintenance purposes (Webb et al. v. U.S., 1919). This resulted in dwindling drug supplies at exorbitant prices (Szalavitz, 1999). Female addicts (most of whom had become addicted through physicians' prescription practices) were left with the choices of withdrawal or finding the economic support (mainly prostitution) necessary to maintain their habit. The inflated cost and the inability to obtain drugs through prior legal channels reduced availability to the now developing black market. Although some women were able to find treatment in private sanitariums; other, less fortunate, women were placed in prisons or state psychiatric hospitals. The majority became reliant on the criminal underworld, facing shadowy lives of social marginalization, degradation, and shame (Kandall, 1996). The passage of these laws, therefore, served to forge the union between women, addiction and prostitution (Szalavitz, 1999). Although the percentage of chemically dependent females fell to about 20% during the early 1900's, the middle of the 20th century gave rise to other "medical miracles" designed to alleviate stress associated with the ever-increasing demands placed on the modern housewife.

The profit from "discovering" new diseases in need of treatment spearheaded pharmaceutical development and marketing. Psychoactive agents developed in the 1950's, along with amphetamines, became popularly prescribed medications and were promoted through advertisements that disproportionately targeted women (for illustrations and a more in depth review of these issues, see Weil and Rosen, 1983).

By the late 1960's about 2/3 of psychoactive prescription drug users and more than 4/5 of stimulant users were women (Szalavitz, 1999). In addition to becoming psychological, physical, and financial targets of the medical and pharmaceutical industries, women have been (and continue to be) victims of other forms of oppression (such as abuse, violence, victimization, poverty, and discrimination) that contribute to the development and maintenance of chemical dependency (Baer et al., 1997).

THE ROLE OF OPPRESSION AND DISEASE

Oppression is defined as an unjust, or cruel exercise of power over another or others (Merriam-Webster's Collegiate Dictionary, 1998). Oppression can be forced or exhibited through deprivation. Hanna, Talley and Guindon (2000) describe oppression by force, coercion, or duress as the act of imposing on an individual or group an object, label, role, experience, or set of living conditions that is unwanted, needlessly painful, and that detracts from physical or psychological well-being. An imposed object, in this context, can be anything from a bullet, a bludgeon, shackles, or fists, to a penis, unhealthy food, or abusive messages designed to cause or sustain pain, low self-efficacy and esteem, reduced self-determination, etc.

Oppression through deprivation is described as an act that deprives another or others of an object, role, experience, or set of living conditions that are desirable and conducive to physical or psychological well-being. It includes the deprivation of loved ones, respect, or dignity. Neglect is another form of oppression in which a person is deprived of love, care, support, or vital services as well as basic material needs such as food, shelter, and clothing. One can also be deprived of one's children, parents, friends, freedom, or even one's childhood (Hanna et al., 2000). Westcott (1986) found the traditional roles assigned to women to be filled with underlying patterns of oppression and second-class citizenry for the majority of all women in the U.S.

Findings published in an in-depth analysis of federal and state health care policies and the status of women's health evidenced current levels of both forced oppression, and oppression through deprivation, imbedded in the lives of American women. The publication of this report was a joint effort between the National Women's Law Center, FOCUS on Health and Leadership for Women Center for Clinical Epidemiology and Biostatistics at The University of Pennsylvania School of Medicine, and The Lewin Group. Relevant findings include: 1) Nationwide, women earn 72.3% of what men earn. State-by-state averages ranged from 87.5% in the District of Columbia, to 63.3% in Alabama and Oklahoma; 2) Women head almost all homeless families, and the two reported leading reasons women become homeless were discrimination and domestic violence; 3) In 1996, almost 5,000 women were killed and many others injured with guns. Women's health suffers because reproductive health, mental health, and the

violence women confront are not given sufficient attention by the nation or the state (National Women's Law Center, FOCUS/University of Pennsylvania, and The Lewin Group, 2000).

Women in the U.S. are three times more likely to be raped than women in European countries. The U.S. reported 118 rapes for every 100,000 women, compared to 43 per 100,000 in Sweden, the country with the second highest rate (Marble, 1995). Approximately four million women are victims of domestic violence each year. Domestic abuse is a leading cause of injury to women in the U.S., accounting for approximately 20-30% of emergency room visits by women. Nation's Health (1994) reports that 25% of all women in the U.S. will be assaulted at least once during her lifetime by a domestic partner. In 1991, 5,745 women in the U.S. were victims of homicide; half of these women were killed by a spouse or significant other.

As a barometer for progressive betterment, hooks (1984) quotes the demands of the government-sponsored conference on women's rights issues which took place, almost a quarter of a century ago, in 1978:

> "The Houston report demands as a human right a full voice and role for women in determining the destiny of our world, our nation, our families, and our individual lives. It specifically calls for (1) the elimination of violence in the home and the development of shelters for battered women, (2) support for women's business, (3) a solution to child abuse, (4) federally funded nonsexist child care, (5) a policy of full employment so that all women who wish and are able to work may do so, (6) the protection of homemakers so that marriage is a partnership, (7) an end to the sexist portrayal of women in the media, (8) establishment of reproductive freedom and the end to involuntary sterilization, (9) a remedy to the double discrimination against minority women, (10) a revision of criminal codes dealing with rape, (11) elimination of

> discrimination on the basis of sexual preference, (12) the establishment of nonsexist education, and (13) an examination of all welfare reform proposals for their specific impact on women" (p. 20).

In 25 years, most of these demands have not been met.

OPPRESSION AND PSYCHOLOGICAL DEVELOPMENT

Karen Horney formulated a social psychological theory that explains women's personality development as a consequence of growing up in a social setting in which they are devalued (Westcott, 1986). Horney was one of the first female psychoanalysts and an opponent to Freud's theory of the psychological development of women. Horney emphasized (along with Erich Fromm and others) culturalization in the development of the female psyche. She proposed that to understand female psychology one must account for this male-created social subordination of women, and, therefore, a psychology of women should be a social psychology, an explication of the interaction of psychic and social factors (Horney, 1992; 1991; 1964; Westcott, 1986).

Horney argued, "inner conflict is the avoidable consequence of the contradictions and dehumanizing elements of civilization as transmitted by parents to their children. The neurotic shares the same cultural context as the non-neurotic but experiences its effects more intensely. In this respect neurotic conflict is simply an extreme version of the psychological conflicts that are typical in a given culture, and the neurotic individual is that culture's prototype. Neurotic suffering reflects critically on the cultural context to which it is a response…the neurotic is a victim whose suffering is not an individual

failure but the rational human response to a culture that is sick" (Westcott, 1986, p. 12-13; Horney, 1992; 1991; 1964).

According to Westcott (1986) neurosis is defined as "human suffering caused by historically created cultural values and social relations" (p. 13). While neurosis may be an individual solution, it reflects the misogynistic values that engendered it; inner conflict may create psychological pain, but the fact that it emanates from cultural patterns (of sexualization and devaluation) gives it social meaning (Westcott, 1986). Given the substantial levels of violence against women tolerated in this country, the development of psychological disorders and chemical dependency, as an alternative coping strategy to living in a pervasive, patriarchal, masculine society, seems a plausible assumption.

Northrup (1994) supports the argument that patriarchy of Western civilization results in addiction. She proposes that self-denial and subordination to the male privilege create a situation in which "systematic stuffing or denying of our needs for self-expression and self-actualization causes us enormous emotional pain. To stay out of touch with our pain, women have commonly used addictive substances and developed addictive behaviors that resulted in an endless cycle of abuse that we ourselves help perpetuate" (p. 6). These conditions relate inherently to the struggles of chemically dependent women when viewed from the perspective of behavior manifested as a self-destructive coping mechanism in response to their inability to overcome systematic, societal, gendered oppression.

Rates of childhood sexual abuse in the general population are found to be much higher for women than for men (Streicher-Bremer, 2000). Depending on the operational definition and method, childhood sexual abuse in the *general female population* is estimated to range from 15-33% (Polusny & Follette, 1995), but much higher rates of sexual and physical abuse among *chemically dependent women* have been well-documented. Some estimates of physical and sexual abuse among chemically dependent women have been reported as high as 75% (Root, 1989). Analysis of data collected by a Canadian women's substance abuse treatment center over a 10-year period found 53% of clients had been raped as adults; 75% had been sexually abused as children (an additional 8% had memory lapses and were unsure); and 74% of women reported involvement in physically abusive relationships (Research Committee of the Women's Addiction Foundation, 1998). Kang et al. (1999) found 51% of women who had been admitted to the Family Rehabilitation Program in New York City had been sexually (24%) or physically (45%) abused.

Traumatic and Abusive Experiences and the Development of Psychiatric Disorders

In addition to developing alcoholism or addiction to other drugs, several researchers have reported a positive correlation between sexual and physical abuse with the later development of other disorders. Radomsky (1995) illustrated the connection between physical and mental health concerns experienced by women during their adult years (such as chronic pain, depression, anxiety, and undiagnosed physical ailments) and family histories of abuse or rigidity or both. Feiring, Taska, and Lewis (1998) found a

strong association between current psychological distress, depression, self-esteem, posttraumatic stress disorder (PTSD), and a history of sexual abuse regardless of age or gender. Gil-Rivas, Fiorentine, and Anglin (1996) also found physical or sexual abuse often contributed to the development of other psychological disorders, such as PTSD, depression, anxiety, anger, self-destructiveness, and suicidal behavior. This association between physical or sexual abuse might be interpreted as the underlying root cause, expressed in various forms (addiction, alcoholism, PTSD, depression, anxiety, etc) as a survival response.

The physiological mechanisms involved in the co-morbid development of other psychiatric conditions that often accompany substance abuse contain similar structural and functional changes that have been found to occur in the brain (Lewis, 1992). These structural irregularities in genes regulate the metabolism and expression of neurotransmitters implicated in maladaptive behaviors including aggressiveness, conduct disorder, attention deficit disorder, novelty-seeking, obsessive-compulsive disorder, affective disorders, and PTSD. Some studies indicate that this type of childhood abuse expresses itself differently in men than in women. Women survivors of this type of trauma exhibit symptoms such as depression, anxiety, or PTSD, while men develop symptoms more consistent with antisocial and sociopathic behavior (Blume, 1990; Jainchill, Hawke, & Yagelka, 2000).

Neurological Changes Resulting from Abuse and the Maintenance of Chemical Dependency

In addition to the utilization of chemicals as a coping response, there exists a growing body of evidence, based on technological advances in the field of neurobiology, that supports a theory postulating that specific neurological changes develop in response to traumatic experiences. These are the same mechanisms that facilitate development of chemical dependency and other disorders. Lewis (1992) found that long-term abuse, whether physical or psychological, can cause changes in brain structure and function. This neurobiological evidence supports the idea that social oppression, in the form of abuse, violence, and trauma experienced by women (or men), plays a significant role in the development and maintenance of substance abuse through neural adaptation that occurs at the molecular, cellular, structural, and functional level (Leshner, 1997).

Therefore, the possibility exists that the physiological makeup, described as "survival mode" of addiction, might be very similar to the physiological brain chemistry related to "survival" experienced by victims exposed repeatedly to dehumanizing events, such as violence, physical abuse, sexual abuse, and trauma. Initial changes in childhood brain function coupled with depression and poor coping skills set up a perfect environment for the development of chemical dependency, which sustains and perpetuates further brain damage, increasing the propensity for exposure to violence, and physiologically deepening the grip and perpetuating the cycle of dependence on drugs and alcohol.

Victimization of women associated with initiation of chemical dependency is also *perpetuated* by the *maintenance* of addiction. Findings indicate that female drug abusers may have greater vulnerability to victimization than males. For example, in a recent study of homicide victims in New York City, 59% of white women and 72% of African American women had been using cocaine prior to their death compared with 38% of white males, and 44% of African American males (NIDA, 1994). Thus, while more males than females use cocaine, its use is a far greater risk factor for victimization for women than men. It is, therefore, critical that the factors involved in the relationship between drug abuse and dependence in women, and physical and sexual victimization (including partner violence) be identified and understood.

Social Oppression and Female Chemical Dependency

In addition to being victims of violence, Marsh et al. (1982) report social reactions to drug and alcohol use by women have been more extreme and negative than reactions to substance use by men. This position is reflectively magnified in our society's treatment of chemically dependent mothers. As the prevalence of Fetal Alcohol Syndrome, "crack babies," infants with substance abuse-related birth defects, and AIDS babies born to addicted women or partners of intravenous drug abusers has risen, public concern has resulted in greater fund availability for research in these areas. This gives rise to a separate, though related concern: women's individual health alone was insufficient to catalyze research for the sake of female lives. Burman (1993) reports "...there is skepticism that these phenomena show more concern for future generations

than for the problems of women themselves, demonstrating a traditional sexist norm... In order for women to receive the help they need in overcoming the deleterious effects of alcoholism and other addictions, barriers to treatment (e.g., sexist biases, lack of environmental and treatment resources, and the inadequate services directed to women's specific problems and experiences) which limit their opportunities to gain a fulfilling quality of life, must be overcome" (p. 35).

Regardless, since 1985, 240 women in 35 states have been criminally prosecuted for using illegal drugs or alcohol during pregnancy, despite the fact that there is no legislation in any state that expressly criminalizes the use of a legal or illegal substance by pregnant women (Midwifery Today, 1999). In 1997, the South Carolina Supreme Court upheld the criminal conviction of a woman charged with child abuse for using crack cocaine during her pregnancy, who was sentenced to 8 years in prison; the U.S. Supreme Court declined to review the case. Ironically (or not), drug treatment programs in South Carolina experienced an 80% decline in the admission of pregnant women in the year following that State Supreme Court's decision (Figdor, 1998).

Szalavitz (1999) found that as a result of the introduction of mandatory sentencing to the federal drug law in the mid 1980's, the number of women in prison has risen 400%. In addition, the average first-time *non-violent* drug sales offender sentenced in the federal system receives a mandatory 10-year jail term, more than twice as long as sentences given the average rapist and just 18% shorter than the typical manslaughter sentence. It is estimated that substance abuse is a contributing factor in 60-90% of

women's crimes, and 80% of inmates never receive drug treatment while incarcerated (Szalavitz, 1999). Once a woman is convicted of a felony, such as the possession or sale of drugs, she is denied even the most basic benefits: no housing, no food stamps, no ongoing drug treatment, all the things she is likely to need to gain the stability necessary to reenter society. Prostitution and selling drugs may be the only employment options (Lovelock, 1997), which create and perpetuate a never-ending cycle.

However, controversial current trends of mandatory treatment and/or jail terms for pregnant or postpartum women, or women with children, raise legal and ethical concerns for clients regarding the impact on and the effectiveness of treatment service delivery systems. Nishimoto and Roberts (2001) found that women who were given custody of their infant stayed in treatment longer than women who did not have custody. The women who retained custody of their child(ren) and who were involved in an intensive day program completed treatment at a much higher rate than those in the traditional program, either with or without custody.

Rather than support mandatory treatment or jail sentencing for women, the use of incentives has been met with success in other types of program approaches. Researchers at John Hopkins University have initiated a program for chemically dependent women designed to give them access to gainful employment and salary incentives for maintaining abstinence. Thus far, 40% of participants (who had "failed" in previous treatment) have sustained long-term abstinence, and the success of the program has been attributed to the use of rewards and contingencies, rather that coercive and aversive

methods (Alcoholism & Drug Abuse Weekly, 2000). Positive reinforcement based on life-sustaining merits is consistent with feminist theory, while other types of treatment remain unavailable, unsuitable, and ineffective in treating the majority of female addicts and alcoholics.

Feminist Critique of the Accessibility and Availability of Effective Treatment and Recovery Approaches for Chemically Dependent Women

BARRIERS TO TREATMENT

While researchers are attempting to identify the most effective treatment strategies, the reality is that the majority of chemically dependent individuals never receive assistance for their problem (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993). This is especially true for the chemically dependent female. In 1989, NIDA reported that 75% of clients in substance abuse treatment were men. Obstacles to treatment frequently cited by women included responsibility for children, insufficient or unavailable resources and health insurance, lack of network supports and lack of appropriate women-sensitive programs (Nelson-Zlupko et al., 1995; Burman, 1993; Wilsnack, 1989).

Persecution by the general public, as well as traditional gender role socialization, heavily influences interpersonal and social barriers specific to women. A survey

reported in Alcoholism and Drug Abuse Weekly (2001) indicated the most significant obstacle to treatment reported by 82% of nearly 200 women in recovery to be the shame of revealing their chemical dependency problems to their family members, boss, or co-workers. Cost of treatment (75%) and lack of family support (57%) were also cited as major obstacles that prohibit women from obtaining help.

Women often encounter internal, external, and structural barriers that preclude them from obtaining treatment. Internal barriers include perception; women often consider alcohol or other drug abuse issues to be a solution or coping response to a specific crisis or social situation. Feelings of shame and guilt, child-care issues, and social stigma associated with substance abuse, as well as an unlikely probability of a correct diagnosis by a family physician or mental health specialist, also impede women from seeking treatment. Opposition from family and friends, inadequate referral networks, lack of women-sensitive treatment services, lack of economic resources or insurance for treatment, and a lack of child care facilities were also reported to be insurmountable hurdles for many chemically dependent women (Beckman, 1994).

Other barriers partially responsible for inequitable access to treatment lie within placement intervention strategies (Blume, 1989). Assessment instruments that measure alcohol-related problems ignore factors important for women and place heavy emphasis on factors more salient for men (i.e., encounters with the law). Nelson-Zlupko et al. (1995) found that chemically dependent women were less likely to be involved in criminal activity, and as a result are less likely to be assigned a treatment program

though the criminal justice system. The three most successful programs include 1) the drinking driver program, 2) the public intoxication program, and 3) the employee assistance model. Clearly these discrepancies indicate poor accessibility, serviceability, and availability of treatment facilities geared to meet the specific needs of the female client.

TREATMENT OUTCOMES

As discussed in Chapter 1, the original research studies designed to develop treatment strategies for alcohol and other drug addiction problems included only male subjects. The information gained from this research was then used as the foundation for examining the etiology of addiction, as well as for the development and improvement of effective therapeutic approaches. The emergence of women into (and out of) treatment facilities began to raise an awareness that perhaps current practices for treating male alcoholism and addiction problems were not efficacious for women.

Chemically dependent women have traditionally been placed with their male counterparts in treatment facilities that utilized therapeutic strategies developed for male clients based on models developed from research studies of alcoholic men. Nelson-Zlupko et al. (1995) remark, "Women's failure rates in traditional drug treatment programs are not surprising given that such programs have been designed primarily by men for male clients and that their approaches have been informed by research conducted on male substance-abusing populations" (p. 49).

However, when studies examined the efficacies of male-oriented treatment for women, they reported equal rates of success for both male and female clients. More than 250 controlled trials have been published on treatment outcomes since 1980 (Miller, 1994). Among those trials, most studies report few differences in treatment outcomes between men and women. However, this ignores confounding factors such as sample size, variability in success rates at time of follow-up, multiple definitions of successful outcome measures, and the implementation of varying treatment strategies, hence making comparisons difficult as well as questionable (Beckman, 1994).

Most male-oriented treatment focused on rehabilitation of the individual in the areas of job training, education, and employment (Marsh et al., 1982). During the 1970's, Levy and Doyle (1974) equated successful treatment completion to employment for men, while success for women was measured by the ability to maintain a relationship with an economically stable male partner.

Likewise, another study indicated counselor assessment requirements of clients' successful completion of the program correlated with employment for men, but uncorrelated for women (Ryan, 1971). Many treatment programs retained these philosophies, perpetuating female stereotypes of passivity and dependency in addition to establishing gender disparity among and between treatment expectations that differentiate successful outcome measures. Other studies revealed that the definition of successful treatment outcomes are often based on recommendations of alcohol consumption rates developed for men that are 3 times higher than those recommended

for women (Jarvis, 1992). This and other factors misrepresent treatment outcomes when determining success rates between male and female clients.

Meta-analyses and literature reviews also suggest that failure rates are similar for men and women in treatment. Several researchers have delineated factors specific to women that affect treatment outcomes (Beckman, 1994; Jarvis, 1992; Root, 1989). One problem in the detection of gender-specific responses to treatment has been the small number of female participants. It is estimated that 92% of the subjects reported in the alcoholism treatment literature between 1970 and 1984 were men (Wallen, 1992). Female participation in most studies would therefore be insufficient for the statistical power needed to detect significant differences. Most reviews of treatment effectiveness noted male-dominated samples, and many studies failed to distinguish between the sexes in the presentation of data. Therefore, the validity of "no gender difference" claims is questionable.

Wallen (1992) also reports that researchers have generally found women's treatment outcomes not to differ from those of men, especially when factors such as age and social class are controlled. While this may be the case in a statistically controlled study, the facts remain that chemically dependent women, as a group, have less education, fewer marketable skills, fewer work experiences, and fewer financial resources than chemically dependent men (Nelson-Zlupko et al., 1995).

There are contradictory findings on the effectiveness of women-only treatment programs compared to mixed-gender settings. Some evidence suggests that women-only

facilities are attractive especially to women with dependent children, lesbians, and women with histories of violence and/or sexual abuse (Jarvis, 1992). Women may prefer individual settings to avoid social stigmatization associated with behaviors that often accompany alcoholism. Jarvis (1992) reported that group therapy worked well for men, but not for women. Individual therapy and self-help groups were supported as beneficial for female clients, whereas mixed-gender group dynamics (also supported by Beckman, 1994) were not found to be a helpful strategy for women. Group dynamics of mixed-gender groups seem to facilitate the recovery process for men, but not for women (Cronkite et al., as cited by Matteson & Allen, 1991). Mixed-gender groups tend to have more men than women and ignore or trivialize women's issues (Woodhouse, 1992). The most comprehensive study to date found all-female programs to be more beneficial in the early stages of the recovery process; while other benefits (such as positive male/female interaction skills) could be gained by women in mixed-gender settings after individual traumatic issues (such as sexual abuse) had been addressed (Burman, 1993).

RATES OF TREATMENT DROP-OUT

Even if the barriers to treatment (i.e., responsibility for children, insufficient or unavailable resources and health insurance, lack of network supports and lack of appropriate women-sensitive programs) are overcome, if not reduced or eliminated, many of those obstacles contribute to drop-out rates once women have entered treatment. Some studies indicate that women are more likely than men to drop out of treatment; and

those who do drop out are less likely than men to have successful outcomes, whether measured as abstinence or reduction in drinking (Beckman, 1994).

Jarvis (1992) reports differences between male and female clients' reasons for dropping out of treatment. Women often cite fear of violence by a domestic partner as a reason for dropping out of treatment. Therefore, provisions for shelter or inpatient treatment may be necessary until the client is equipped with enough skills to leave the abusive situation (Beckman, 1994). This position supports the recommendations of Root (1989):

> "Many approaches to the treatment of addictive behavior are based on a univariate concept of alcoholism developed from the male experience and recovery and may not always be appropriate for women or for those whose addictive behavior is a post-trauma coping response... Understanding the negative, long-term impact of sexual victimization on internal affective and cognitive states strongly suggests a client's need for concurrent development of coping skills as she strives to reduce her substance abuse. Women who are currently in sexually or physically abusive relationships may not be able to give up their substance abuse until they are out of physical danger from the relationship" (p. 547).

Several studies have reported the number of supportive relationships to be a significant predictor of treatment outcomes, and, for women, the quality of these relationships was determined to be equally as important (Beattie, 2001; Beckman, 1994). Yet, Klee, Schmidt, and Ames (1991) report that female alcoholics receive less support from family and friends than nonalcoholic women, both as children and as adults. Since women tend to leave treatment due to external pressure, family responsibilities, difficulty with interpersonal adjustments to in-patient settings, and the failure to attend to unique

female needs, such as child-care and victimization issues, strategies must be developed and implemented in order to better meet the needs of the chemically dependent female client.

Aharon (2000) found regular client attendance of treatment center aftercare services, aftercare and 12-step groups combined, or AA participation alone was significantly associated with recovery at 3-month post treatment follow-up. This sample was comprised of a group of 228 mixed-substance, mixed-gender, substance-abusing clients who entered a private addiction rehabilitation hospital for residential treatment. Although this would support the utilization of aftercare and 12-step meeting participation, it does little to identify characteristics specific to individuals that may prohibit or discourage attendance of 12-step program participation.

Several studies suggest participation in treatment aftercare and 12-step programs, as well as levels of spirituality, to be important in the recovery process. For instance, Pardini, Plante, Sherman and Stump (2000) examined the relationship between religious faith, spirituality, and mental health outcomes in 236 individuals recovering from chemical dependency. Subjects reporting high levels of religious faith and religious affiliation chose to rate themselves as being more spiritual than religious. Individuals reporting higher levels of spirituality had better coping abilities, greater resilience to stress, greater perceived social support, were less anxious and were more optimistic. Thus, recovering individuals who were more spiritual had more positive mental health outcomes. White, Wampler and Fischer (2001) examined whether higher levels of

spirituality among 252 participants (aged 17-69 yrs) from a variety of treatment settings were associated with indicators of successful recovery. The results indicated that spirituality was an important element in recovery and supports inclusion of spirituality as part of recovery programs.

Jarusiewicz (1999) explored the relationship between an individual's level of faith and his or her success of addiction recovery, recognizing (a) that differences exist between spirituality exhibited by individuals and their identified religion(s) of their childhood and adult life and (b) the dynamic quality of spirituality. Two groups of 20 addicted individuals (12 males, 8 females, reflecting the average male/female ratio in the treatment center) were studied. The first group represented those in the recovery process, with at least 2 years of abstinence from any addictive substances, while the second group represented a relapsing population. The researcher found that those in the recovery process had statistically greater levels of faith and spirituality than those continuing to relapse. In fact, those in the recovery process had greater levels of faith than measured in the general population, whereas the opposite was true for the relapsing population. Importantly, those in recovery who evidenced significant levels of spirituality did not choose to express this spirituality in conventional religious contexts but, rather, stated 'independent' or no religious affiliation. Therefore, success among individuals in the recovery process was related specifically to spirituality measures, and expressly NOT related to religious affiliation.

Knight, Logan and Simpson (2001) examined factors associated with recidivism in a treatment center which provides specialized services geared specifically toward the needs of pregnant and parenting women. Education level, peer deviance, and recent arrests were found to be significant predictors of treatment completion. Support for educational programming and services that address social deviancy were recommended, but quantitative inquiry limits the acquisition of knowledge regarding the relationship(s) that may exist between these variables. Necessary and valuable insight into the problems associated with addiction and women can be gained from female clients in chemical dependency treatment. However, this ignores the needs of individuals who lack access to, or who have dropped out of, treatment. Neither do these studies provide information for addressing troubles unique to women, nor does it illuminate effective long-term recovery strategies.

The way we see the world is constructed from our knowledge base. Therefore, in hierarchical systems, the individuals in positions that control the content and access to information become, creators of perception, and hence, creators of reality. In addition to political bodies that govern the lawmaking process in our society, there are also political processes governing the acquisition of information. Traditionally, women were denied access to and their experiences excluded from, existing bodies of information.

FEMINIST CRITIQUE OF POSITIVISM

Feminist research has long been concerned with patriarchal principles inherent in the scientific method. Science, knowledge, and wealth are inextricably intertwined with

power. Individuals with formal education tend to be those who possess "scientific" knowledge; those with knowledge tend to possess the greatest potential for financial gain; those who possess wealth in turn influence the topics, investigator, and method of scientific inquiry; and therefore, in turn, they possess power. Baer et al. (1997) refer to this as hegemony. Hegemony refers to the process by which one class exerts control of the cognitive and intellectual life of society by structural means as opposed to coercive ones. Those historically associated with knowledge came from universities generally filled with educated men from the ruling class. Science, traditionally, has been performed by men, who have been educated by other men, and has been based on knowledge obtained from a positivist paradigm designed to investigate matters of importance relative to the male agenda. Therefore, science is "made" to establish "facts" by a self-perpetuating group: by the chosen, for the chosen (Hubbard, 1992).

Political and social realities can be integrated in subtle ways so they are hard to distinguish in descriptions presented as biology. Objectivity as defined by empirical scientists mask these political inroads into scientific inquiry. This scientific way to know has been labeled 'objective' and identified as masculine (Hubbard, 1992); it assumes knowledge gained through observation is more certain than any other knowledge and that things that we observe have more claim than anything else to existing or being real (Allen, 1985). Researchers accomplish "objectivity" by looking at a selected slice of nature, with disregard for the effects inherent in the act of observation, or for influences that do not exist in the isolated part, but only in the context as a whole.

Conversely, artistic, intuitive, and empathetic ways of knowing are considered 'subjective' and feminine. "Knowledge has become gendered because the Western world values objectivity over subjectivity; and therefore, men's knowledge over women's, so 'feminine' ways to know are by their nature inferior" (Hubbard, 1992, p. 8). Qualitative research is grounded in the assumption that experience is culturally, socially, and subjectively determined. It is for this reason that the naturalistic paradigm has been devalued by the scientific community. The epistemological differences reflect different worldviews of objectivity and subjectivity.

Another concern of feminist research is the language of the scientific method. The reification of scientific language imparts a false sense of authority and removes the temporal and contextual relevance of the researcher to imply the occurrence did in fact transpire in the world (Hubbard, 1992). The removal of person, time, and place also removes personal responsibility and furthers the ascent of science (and scientists) to the level of omnipotence and power. The goal of naturalistic inquiry is to impart the personal meaning of lived experience to the reader.

A third point of contention in the feminist inquiry is value-based versus value-free results. Quantitative value is defined in numerical terms and expressed in units derived from theories of probability. The value in qualitative inquiry is based on the subjective experience and personalized meaning for the individual. It recognizes multiple realities and does not limit its investigation to the pursuit of "the one right truth."

The dichotomous nature of Western thinking pits one method considered by empirical scientists to be superior (quantitative) against one method considered to be inferior (qualitative). Morgan and Smircich (1980) suggest qualitative and quantitative methodologies lie on a continuum rather than in mutually exclusive categories. They argue that the grounds for knowledge in each of these methods are different based on the assumptions critical to each paradigm. The point is not that one paradigm is superior to the other, but that they are both legitimate and valuable methods for gaining knowledge that promote understanding - as long as the limitations are acknowledged and the interests of those who benefit are clearly stated.

Theoretical Framework: Feminist Theory

The feminist movement is responsible for establishing a scholarly method designed to root out causes and consequences of discrimination and oppression of women through the deconstruction of social systems, and by promoting a social vision and political practices that support women's equality (Lauver, 2000).

Feminist theory is concerned with revealing and dismantling the forces that create and maintain unequal power structures nested within systems. These systems tend to uphold patriarchy and perpetuate oppression. These themes are the basis of feminist theory and provide the theoretical framework for the current study. The theoretical framework for this study suggests that factors influencing substance use, abuse, and dependence cannot be understood independently of our knowledge of the roles traditionally ascribed to women.

Although a variety of beliefs and political stances divide the feminist movement into different categories, Burman (1993) states "they all basically adhere to the oppression and subordination of women and the lack of power to bring about change as the foundation for the inability to transcend their 'second-class' status in a male/patriarchal-oriented and dominated society" (p. 62).

FEMINIST CRITIQUE OF TWELVE-STEP PROGRAM PHILOSOPHY

Feminist theory is used to dissect power structures nested within social systems. Inherent in this theory are the concepts of construction and deconstruction. Gender is a social construction, an invention of human societies. What we make of gender and how we define male and female have an influence on how people see themselves and the world. The meaning of gender has an influence on behavior, social arrangements, and the organization of crucial social institutions, like work or recovery. Most mental health professionals and physicians routinely refer chemically dependent clients to AA and related programs as part of drug treatment and aftercare (Ellis & Schoenfeld, 1990; Humphreys, 1993) even though empirical studies investigating how these spiritually driven programs assist in substance abuse treatment are virtually non-existent (Peteet, 1993). Therefore, concern has been expressed from the feminist standpoint regarding the general applicability of 12-step programs. AA, the largest and original 12-step program reports a 50% drop-out rate after only three months (Chappel, 1993), which according to some, is no better than no treatment at all (Miller, 1986).

Many feminists have described AA as a white, middle-class male dominated organization that promotes dependence on a "Higher Power" (Hall, 1994). Early AA members developed a recovery program of 12 steps that emphasizes surrender, belief in a "higher power," moral self-inventory, restitution, spiritual meditation, and helping others (Hall, 1991). AA was started in 1935 by two white, middle class, Protestant men who wanted to help themselves abstain from alcohol through the support of each other and those like them (Hall, 1994). It combines social interaction, group meetings, and spirituality into a way of life (Denzin, 1987). Even though AA has grown into an international entity and appears to be a positive influence in maintaining recovery for those who are well affiliated into its ranks (McLathchie & Lomp, 1988), for decades, AA's membership has remained essentially male. Integration of women has been a consistent struggle (Leland, 1984). For example, AA literature continues to be rife with sexist language and depicts the "Higher Power" as a male god, despite longstanding protests from people deeply offended by these terms and depictions (Hall, 1994). Thus, the linguistic and conceptual structures that shape and discipline our imagination of male and female are created, as well as the meaning of gender itself, organizing what we take gender to mean in the structure of everyday life. In this manner sexist language imposes a point of view not only about the world to which it refers, but also toward the use of the mind in respect to this world.

Language highlights features of the objects it represents, certain meanings of the situations it describes. The word, no matter how experimental or tentative or

metaphoric, tends to replace the things being described (Hare-Mustin & Marecek, 1990). Once designations in language become accepted, such as the concept that God is a "He," one is constrained by them not only in communicating ideas to others, but in the generation of ideas as well (Bloom, 1981). In this manner, the meanings represented in language, such as conferring maleness to an omnipotent "god" whom an alcoholic must "surrender" and admit powerlessness become problematic for marginalized groups, and especially insidious for women who may have been victimized by dominating, violent males. Segregated AA meetings have evolved over the years for those subgroups who are not well affiliated, such as women, gay men and lesbians, and people infected with HIV (Hall, 1994). The existence of such meetings is considered evidence of mainstream AA's continued cultural biases.

Several feminist researchers have questioned the program's relevance to marginalized people and its potential for eroding political activism with its individuation of social problems (Herman, 1988; Johnson, 1989; Tallen, 1990). Johnson (1989) argued that the theory of addiction which posits individual culpability is harmful to women in its denial of the political, social, and economic realities that structure women's lives. Eastland (1995) suggests that many of the characteristics of the individual addict (self-centeredness, dishonesty, denial of responsibility, perfectionism, dependency) are characteristics of our broader social system. Efforts directed toward changing only the individual detract attention away from the larger factors that interact with or underlie many social problems. Self-help programs assume that current social and economic

arrangements work for the general good; therefore, the addicted person must change. Social institutions that may cause and sustain substance abuse are not challenged (Morell, 1996).

Most feminist resistance and criticism exists because members of the programs are taught that their addiction means that they are powerless over alcohol or other drugs and that recovery requires acceptance of powerlessness. The concept of powerlessness has been associated with the express concern of fostering dependence on others; specifically on the "group" of AA (Vick et al., 1998). This concept is viewed as detrimental by those (feminists) who consider powerlessness to be associated with promoting weakness and subservience among the already marginalized population of chemically dependent women (Davis, 1997). However, the addiction model of intervention to meet the sociopolitical needs of specific persons or groups has not been the hallmark of the 12-step movement (Saulnier, 1996). AA and other 12-step programs hold that problems with drugs and alcohol are best understood by examining the character of the person who suffers from a disease or state of addiction. These individual problem- and lack of wellness-focused solutions construct the knowledge, or frame of reference, that structures the initial experiences of women upon introduction to the majority of recovery oriented solutions. Therefore, feminist criticisms include AA's adherence to the medical model of disease, instead of focusing on strengths from a wellness perspective (Vick et al., 1998).

Additionally, powerlessness is said to apply to many areas of addicted people's lives; they have no control over persons, places or things. Furthermore, 12-step program members are urged to accept their powerlessness (Saulnier, 1995). However, feminists purport that women need power to advance their own development (Miller, 1986). Moreover, instead of fostering dependence through "powerlessness," the greater the development of each individual the more able, more effective, and less needy of limiting or restricting others she or he will be.

As qualitative inquiry gains acceptability as a valid research method (at least in certain circles) some researchers *have* begun to focus on the life events related to the addiction process as experienced from the perspective of chemically dependent women. Despair and loneliness were reported by Hunt and Seeman (1990) to be the predominant themes in the interviews conducted with a group of 15 women in treatment for alcoholism. A comparative analysis of interviews conducted with 15 women with long-term sobriety reflected relationships as central to the major reconstruction of their lives. Sales and Murphy (2000) found a strong relationship between problematic levels of internalized shame (regardless of developmental source) and difficulty in maintaining abstinence for alcoholic women in recovery. Norman (1997) found that increased length of recovery was associated with decreased levels of shame. This indicates internalized shame (regardless of the cause) to be an important issue to address for women negotiating a path to recovery.

Another study conducted by Rankin (2000) reported the emergence of three major themes developed from a naturalistic inquiry that utilized interviews conducted with 10 women in recovery from alcoholism. The predominant theme was stated to be the importance of interpersonal processes/relationships for women in recovery; the magnitude of feelings related to pain, low self-esteem, and depression; and the identification of spirituality as an essential recovery experience.

Dean (1996) conducted a phenomenological study that explored women's addiction from a unique theoretical orientation based on Jungian psychology and feminist theories of female psychopathology. Themes important in the process of recovery from addiction to drugs and alcohol were seen as a meaningful process of transformation and individuation that involved both growth and healing of old wounds facilitated through talk and relationships with others and with a Transcendent other.

A cohesive model developed from the trauma of an entire culture and the devastation experienced by American Indians based on their response to the loss of half of their entire civilization is presented by Lowery (1998). She examined recovering American Indian women's personal stories of the addiction and recovery process. Four concepts: (1) balance and wellness, (2) the colonization experience and addiction as a crisis of the spirit, (3) issues of abuse, including sexual abuse, and (4) a time of healing were presented. The information gathered in this study was then developed into a qualitative model of long-term recovery for American Indian women based on their cultural history and spiritual beliefs (Lowery, 1999).

The model Lowery (1999) developed embraces American Indian culture and recognizes the "trauma of a people" and reflects the circle of healing through the "science of the spirit." Abuse issues experienced by the Indian women in various forms were given voice to "break the cycle," "expand the circle," "reclaim the mother" (acknowledgment and understanding of the realities of the past) and "develop a new continuity" focusing on contributions to American Indian peoples as well as to others. The Indian people recognize that they are in the time of the Seventh Generation. The Seventh Generation was prophesied to be a time of healing; the power of the Spirit is evidenced to them by the prophesied birth of the white buffalo, and healing is being promoted through the solidarity of its people (Lowery, 1998). This analysis illustrates how the difficulties of the individual are transgenerational and inextricably linked with history and surrounding circumstances, and emphasizes the importance of culture and empowerment for recovery of the self and future generations.

This view runs counter to Western philosophy's separation of the mind and body. Rather than continue to explore addiction, treatment, and recovery strategies from the perspective of the society that possibly perpetuates and supports the underlying factors of addiction while placing blame on the chemically dependent woman, it would seem prudent to examine these same problems (and the meanings given them) based on the personal experience and perspective of women in other cultures. The invaluable lessons grounded in the experiences of recovering women have the potential to illuminate and promote understanding. Better understanding has the potential to help program

directors develop effective holistic and comprehensive methods for empowering the individual in treating the malady of the mind, the body, and the spirit.

Further investigation of the successful strategies utilized to overcome problems encountered and surmounted by recovering women and the importance of detailing their experiences of the addiction and recovery process from within their personal worlds are imperative if we are to offer encouragement and hope to the women around the globe who find themselves in such a disempowered state. This study was designed to examine the process of addiction and recovery from within the framework of the experience of chemically dependent women in recovery. The women in this study had been clean and sober between 5 and 22 years.

INTERPRETIVE INTERACTIONISM

Denzin's (1989) Interpretive Interactionism is a qualitative method heavily influenced by feminist theory. It is designed to reveal oppressive relationships of gender, power, and domination that may exist between public policy or institutions and individuals' private lives. Only through the identification of the power structure from the contextual viewpoint of the individual for whom these organizations are designed to serve is change made possible. Discussion of this method is the topic of Chapter 3.

CHAPTER 3: METHODS

Introduction

This chapter describes the research design for this study. The philosophy of Interpretive Interactionism is dedicated to the examination of lived experience. Interpretive Interactionism attempts to make the "problematic" encounters of ordinary people directly available to the reader. It recognizes that each experience is distinctive, evolving, and filled with multiple and fluid interpretations. The typical "why" question is replaced with "how"; therefore, the question in the current study was not "why" women become chemically dependent or recover from addiction, but rather "how" they experience these processes from within the context of their own personal worlds. The interactionist (or researcher) seeks to understand and interpret these worlds (Denzin, 1989).

Interpretive Interactionism is ideographic, emic, and naturalistic. An ideographic study values the uniqueness of each individual case and assumes that "no individual is ever just an individual. S/he must be studied as a single instance of more universal social experiences and processes" (Denzin, 1989, p. 19). Emic studies reflect the perception of the participant, as opposed to etic, which rely on external observation. Naturalistic studies emphasize the importance of context and do not separate the phenomenon of interest or the participant from the context of their experience. With naturalistic studies, every situation is novel, emergent, and filled with multiple, often

conflicting meanings and interpretations. These components honor the individual's experiences and the ability to relate these experiences.

Central to Interpretive Interactionism are the transforming moments of problematic experience, or epiphanies. Epiphanies are studied because they are the life-changing events that mold, structure, shape, and convey meaning to the individual's perception of the world. Epiphanies are transformational experiences, which if not understood at the time of occurrence, take on an important meaning during retrospection. Indeed, many of the women in this study had completely reformulated the meanings of their experiences that occurred in the addiction process. More importantly, they considered their present lives to be completely transformed. Many had illuminative spiritual experiences that immediately changed them; others experienced epiphanies that were cumulative, taking place over a number of years. In order to learn and understand any phenomenon, it is critical to view the construction of crisis relevant to the phenomenon through the eyes of the participants and from within the frame of reference created by their personal experiences.

DESCRIPTION OF PARTICIPANTS

Participants in the current study were self-proclaimed addicts/alcoholics (see definition of terms) women, who attended 12-step programs and had been abstinent from unprescribed mind or mood altering substances for a period of at least 5 consecutive years. Just as chemical dependency is a process that affects the mind, body, and spirit of the addict, recovering from chemical dependency is an ongoing process that involves

healing of the mind, body, and spirit. It often requires years for the damage from the chemicals themselves, as well as from any other associated trauma(s) to be repaired. Personal observation and key informants in the substance abuse field suggest that stability in these areas, as well as a more realistic perspective of life events, has most often been attained after a five-year period.

The average length of clean time/sobriety for the women who participated in the current study was 14 years. All the participants continue to attend 12-step meetings. Each woman had been in at least one relationship with a significant other/partner and has at least one child.

NUMBER OF PARTICIPANTS

In an interpretive interactionistic approach, the number of participants is guided by the quality of redundancy. Recruitment of additional subjects generally continues until categorical saturation and redundancy occur (this is possible because data analysis is ongoing and occurs simultaneously with the interview process). Parse (1990) suggests redundancy occurs when a pattern is sensed in the interviews of a number of participants. In the current study, the women's stories provided such rich detail I thought it would be impossible to know when redundancy had been reached. However, after conducting the first six (of seven) interviews, the stories seemed to share common threads; the particulars of each story varied, but similar patterns, feelings, and sense of emotion resonated throughout each interview. The density and richness of narrative provided by the final participant (for a total of seven) was considered sufficient by the research team

to cease the interview process and apply the remaining processes of the method. The idea of generalizability (which is related to a large number of subjects) was not relevant. Qualitative analysis values depth (detailed accounts from a smaller number of participants) rather than breadth (a sparse description from many participants). In this investigation, seven women recovering from chemical dependency participated.

ACCESS TO THE POPULATION

Learning the language and culture of 12-step programs is an integral part of the interpretive process for the current study. Participant observation, open-ended interviewing techniques, and therefore attendance of AA and NA meetings in the Central and Northeast Texas Areas served to establish trust, familiarity, and rapport with the members. I have read *Alcoholics Anonymous* (1976), also called the "Big Book" utilized by AA, *Narcotics Anonymous* (1988), also called the "Basic Text" developed and utilized by NA, and many of the pamphlets and books written about each of the fellowships. Access to the population and participant recruitment are discussed at greater length in the following sections.

SELECTION AND RECRUITMENT

Before beginning the selection process, one interview was conducted with a fellow student, who had participated in a 12-step fellowship other than AA or NA This procedure was conducted to rehearse the interview process and to allow the researcher to

become comfortable with the technique of gathering the data. After the researcher was at ease with the method, participant selection began.

The first three participants were recruited from AA and NA 12-step programs in the Northeast Texas area; the remaining four participants were recruited from AA and NA programs in the Central Texas Area, lending geographical diversity within the state of Texas. This form of sampling is known as purposive sampling (Lincoln & Guba, 1985), in which subjects are selected on the basis of some criterion of interest: in this case, women who had experience with the addiction and recovery process. Maximum variation among participants was not a selection requirement or actively sought, but the women did vary in age, education level, as well as past and present socioeconomic backgrounds.

The initial participants (n=3) from the Northeast Texas area were women with whom I have established intimate friendships over a number of years. The next two participants (n=2) in the Central Texas Area were key informants (women with whom I had an established rapport). After interviewing these two key informants, I then asked them to refer me to other women, who had been in recovery for at least five years, and whom they thought would be willing to share their experiences with me. They each knew, and recommended the names of several women whose experiences they recognized as fitting the selection criteria. I then approached these women, one by one, as they crossed my path, until I found two more women who agreed (only one woman I approached declined) to participate, for a total of 7 (n=7) participants. The initial three

participants, I know intimately; the next two participants, I know by name and face; the last two women who agreed to participate were unfamiliar to me.

The process of referral is known as the "snowball" method of sampling, described by Patton (1990) as simple referral from the original informants who were acquainted with other potential participants. This process is discussed further under the "capture" section of this chapter.

Data Collection Process

After an informant agreed to participate, we set a time and place (most convenient for her) to conduct the one-on-one interview. Three of the interviews were conducted in the participants' homes, three were conducted in my home, and one was conducted at the woman's place of employment after business hours.

Confidentiality issues and human subjects forms were explained and signed upon arrival (see Appendix E). Life-history interviews were conducted with each participant. For the Interview Guide utilized in interviews 1-5, see Appendix A; for the modified version utilized in interviews 6 and 7, see Appendix B (for an explanation of modifications, refer to "Interview Questions" section under "Bracketing" in this chapter). The interviews were audio taped and transcribed verbatim. An outside transcriptionist transcribed three of the interviews. Only first names were used in the interviews and the transcriptionist lived in another city, so adherence to confidentiality was strictly observed. I transcribed the remaining 4 interviews, and, at the end of the transcription, the search and replace function was utilized - by me and by the outside transcriptionist -

to replace the participants' names and the names of other individuals mentioned in the transcript with an alias.

Transcriptions were printed for hard copy and also saved on computer disk. No personally identifying information appeared on the transcriptions. The tapes were erased after the study was completed. Audio cassette tapes (until transcribed and erased), transcriptions, and computer disks were kept under lock and key at all times in the researcher's home, except when the outside transcriptionist had possession of the audiotapes.

Any identifying information obtained in connection with this study has and will remain confidential and will be disclosed only with their permission.

Research Design

NATURE OF THE STUDY

Interpretive Interactionism, with an emphasis on ethnography (cultural descriptions) informed the research design. The steps in the interpretive process involve (1) framing the research question; (2) deconstruction and critical analysis of prior conceptions of the phenomenon; (3) capturing the phenomenon, which includes locating, situating, and obtaining multiple instances of the phenomenon as occurs in the natural world; (4) bracketing the phenomenon, or reducing it to its essential elements, cutting it loose from the natural world so that its essential structures and features may be uncovered; (5) construction, or putting the phenomenon back together in terms of its

essential parts, pieces, and structures; and (6) contextualization, or relocating the phenomenon back in the natural social world (Denzin, 1989).

Step 1: Framing the Research Question

The research question is framed by the self-stories of the researcher and personal experience stories of the participant. Since the researcher actively seeks to make his or her own personal experience part of the research, he/she consciously seeks to locate individuals who have gone through those experiences the researcher wishes to understand (Denzin, 1989). I sought individuals with experiences similar to my own. My own experiences included a personal traumatic encounter at the age of 13, followed by necessary silence due to feelings of guilt and shame stemming from my inability to reconcile my experience with my religious upbringing. For many years, the stigmatization of drug addiction added to my feelings of shame and guilt. As a result, I attracted into my life other individuals who, like myself, perpetuated more violence and abuse. Rage at the entire world was ultimately my final and singular feeling.

After being given an outlet for my rage through recovery and a voice through education, I began a search to discover if my experiences were unique; and if not, could they benefit other women still carrying the baggage of the past? I wanted to know how other women had experienced the addiction and recovery process; I also wanted to know how our society functions to uphold an environment of abuse and yet ultimately blames the individual for the problems it created. This information is vital for policy reformation if true change and healing are to be permanently sustained in American

civilization. Just as my personal experiences have framed this research, these experiences also influence how I view the world; hence, as an investigator, I must recognize the biases these experiences produce and how they affect the way I perceive and view addiction and recovery.

Pre-Understandings To Be Bracketed

More than an observer, the researcher is a primary investigative tool in qualitative research (Lipson, 1989). Interpretive Interactionism recognizes the researcher's experiences as an inherent part of the process of recognizing personal investigative biases so they may be understood and bracketed ("separated out," or set apart from the research through the process of public acknowledgment). With the researcher recognized as a primary research tool, Interpretive Interactionism necessitates the statement and acknowledgement of the researcher's experiences related to the phenomena. My pre-understandings of the addiction and recovery process are influenced by quantitative research methodology, feminist theory, personal spiritual experiences, and 12-step oriented recovery programs. I have a strong background in the scientific research method from my undergraduate (B.S. in Kinesiology), master's (M.S. in Kinesiology with an emphasis in Motor Control), and current doctoral (health-related, community-based research interests) level training programs. This training is primary in the ethical conduct of sound research practices and has been vital for recognizing the limitations of the quantitative method in relation to the study of certain social and behavioral problems.

Apart from my academic training, my personal experiences revealed the failure of substance abuse treatment programs, as well as the health care industry in general, to provide me with salient support or information for the problems I encountered specifically as a female addict. This lack of support and information perpetuated a search for personal recovery, which has (quite unexpectedly) turned into a spiritual journey. Motivated by desperation, I was searching only for relief from active addiction; what I have received in addition to this relief continues to exceed my wildest imagination. I have developed a faith in God (of my own personal understanding) through the process of watching miracle after miracle take place in my own life, as well as in the lives of others. Though achieving personal success (which I consider to be the ability to eventually find contentment within myself regardless of my external circumstances - at least most of the time), I have also watched many women who were less fortunate in their recovery endeavors. In this manner, my experiences influenced my search to seek other women willing to share their own stories, whose paths have led them successfully through the addiction and recovery process.

The phenomenon of the addiction and recovery process as interpreted through the lived experiences of women cannot be studied through quantitative methods (i.e., a pre-determined set of variables isolated within a particular group and then compared to the effects of the same variables on a matched separate group). The premises used to control for error in a quantitative experiment are not appropriate for understanding meanings given to experiences from the perspective of the individual. The goal of Interpretive

Interactionism is to acknowledge the researcher as an investigative tool who brings to the table all of his/her past experiences. Interpretive Interactionism recognizes and values these experiences as assets and uses them as valuable information upon which to build a foundation. Instead of attempting to control personal biases through error elimination (as in quantitative methodologies), qualitative inquiry requires that personal foundational experiences be recognized and brought into the hermeneutic circle as part of the interpretive process. This process of inquiry is often referred to as "hermeneutics" or the hermeneutic circle. Heidegger (1962) states, "This circle of understanding is not an orbit in which any random kind of knowledge may move…it is not to be reduced to the level of a vicious circle or even of a circle which is merely tolerated…What is decisive is not to get out of the circle but to come into it the right way" (as cited by Denzin, 1989, p. 53).

The participant further defines the problem that organizes the research. The researcher thinks reflectively, historically, comparatively, and biographically to uncover how these experiences occur. Based on my personal experiences, I thought about how our society historically (and currently) treated women in general. I considered the experiences of violence from within a culturally accepted norm and the effects of authoritative domination and abuse on disempowered groups, specifically female addicts. The examination of how problematic turning point experiences are organized, perceived, constructed, and given meaning by interacting individuals is thus formulated into a single question (Denzin, 1989). I synthesized what I thought to be relevant

personal epiphany experiences compared to the stories I have heard from scores of women recovering in NA or AA 12-step programs, and utilized this information to formulate the question in the current study, which is, "How do women who have relied on the framework of 12-step programs personally experience the addiction and the recovery process?" After the research question has been framed and formulated, the perspective of Interpretive Interactionism, the theoretical framework of which hinges upon feminist theory, is used to deconstruct the related literature.

Step 2: Deconstruction

Deconstruction involves examining the existing literature to expose prior conceptions and biases that surround the phenomena in question. This process allows the current study to be located within and against the existing body of literature. The deconstruction phase of this study can be found in Chapter 2. The process of gathering the data begins after deconstruction and is termed capture.

Step 3: Capture

Capture involves going into the worlds of social experience where the research question occurs and is depicted in the following steps: 1) securing multiple cases and personal histories that embody the phenomenon in question; 2) locating the crises and epiphanies of the lives of the persons being studied; and 3) obtaining multiple personal and self-stories from the subjects concerning the topic or topics under investigation (Denzin, 1989).

Capture makes the phenomenon being studied available to the reader. It presents experiences as they occur, or as they have been reconstructed. When stories are to be grouped around a common theme, Thompson (1978) and Denzin (1989) suggest that multiple stories be collected. The biographical experience, the event, how the event is experienced, how the event is defined, and how the event is woven through the multiple strands of the subject's life, constitute the focus of interpretive research. Biographical experiences are related through narratives; narratives may be either self-stories or personal experience stories. *A self-story* is "a narrative that creates and interprets a structure of experience as it is being told" (Denzin, 1989, p. 38); whereas, a *personal experience story* is "a narrative that relates the self of the teller to a significant set of personal experiences that have already occurred" (Denzin, 1989, p. 38).

In the current study life-history interviews were conducted with each participant. First, self-stories and personal experience stories that exemplified epiphanies related to addiction and recovery were extracted from each individual interview. "Thick description" captured the nuances inherent in the personal experiences of these women.

> "Thick description does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events for the person or persons in question. In thick description, the voices, feeling, action, and meanings of interacting individuals are heard" (Denzin, 1989, p. 83).

Capture in the present study led to the places where recovering women gather, such as AA and NA meetings. I attended meetings conducted within and apart from treatment institutions for separate reasons. Most participants at institutional meetings are in detox, and either very new to recovery or have recently relapsed. Institutional meetings provided an understanding of the addiction and early recovery process, while non-institutional meetings provided places to locate women who had been chemically free for at least five years. I listened to the stories of many of these women and have developed the utmost respect and admiration for them.

After comparing and contrasting my personal experience with what I had learned by listening to these women's stories, and with the existing literature, I then approached those women who were clean and sober for at least 5 years. I explained my study and asked if they would be willing to be interviewed. In essence, capture is data collection. The next stage of the interpretive process is called bracketing, or data analysis.

Step 4: Bracketing

The process of bracketing involves searching for, isolating, and listing key words, phrases, and statements that organize the meanings of a text. In the current study, the interviews were read and re-read. Bracketing involved finding initial concepts or impressions that seemed to "stand out." They then were highlighted, and similar words and phrases noted. All common codes were then listed, and then grouped and re-grouped until they seemed to cohere in a logical pattern. These groups, being "cut away" from the transcripts, could then be viewed as a cluster with common

characteristics. These characteristics were grouped under headings, or sub-themes, from which, eventually, the five major themes were derived. This process enables the researcher to get a general "sense" of the phenomenon derived from specific life experiences.

Interview Questions

The questions for the life history interviews were developed from the knowledge acquired through immersion in the literature and interaction with many women over a period of years prior to the actual fruition of the study. Modifications were made on the advice of the research team for the last two interviews; the purpose of these modifications was to streamline the information for clarification.

Data Management

After the interviews were transcribed, cleaned, and reviewed, they were then imported into the qualitative statistical package, QSR NUD*IST 4 (2000), where the interviews were then numbered line-by-line and printed. This process of line-by-line numbering aids in coding, grouping, and locating data for future use.

Coding occurred in phases, or levels. First level coding highlighted any significant statements or key words. Memos were recorded in the margin next to the numbered lines with corresponding text(s) (see Appendix F). This process continued for each interview. Memos were used as a tool for initial thoughts about the data or questions that might need future clarification. I worked back and forth between the

interviews as they progressed and noted consistent patterns within the addiction and recovery process. All codes noted in the first level coding were compiled into a list. As analysis proceeded, some codes were combined into larger categories. Second level coding entailed the extraction of commonalities derived from the first level coding process. Second level coding proceeded as more interviews were conducted and coded. Third level coding identifies emergent themes underlying those commonalities. Member checks (i.e., returning to the interviewees for clarification) were performed, categories were reorganized, and the interviews re-read until major themes were extracted.

This was an ongoing process in which I worked back and forth between the data, my memos and journal, as well as with the research analysis team. The research team consisted of two PhD's familiar with Interpretive Interactionism and one doctoral student familiar with qualitative analysis.

Each analysis team member received copies of all interviews and performed first level codings independently of one another. Comparisons, reflections, and suggestions were formulated over several meetings with team members and questions for further clarification were identified. These questions (identified in the analysis) were then taken back to the selected participants for input and clarification. Member checks were performed at periodic intervals to clarify or confirm ideas as they emerged throughout the analysis process. A sample of first and second level coding will be included in the appendices.

Step 5: Construction

"Construction" attempts to interpret the event or process by classifying, ordering, and reassembling the phenomenon back into a coherent whole. Essentially, construction involves (1) listing the bracketed elements of the phenomenon, (2) ordering the elements as they occur within the story, (3) indicating how each element affects and relates to the other elements, and (4) stating how the elements cohere. Bracketing leads the interpreter to inspect these problematic interactions, or symbolic expressions, in terms of their essential, recurring features or key elements (Denzin, 1989), and how the lived experience alters and shapes the phenomena in question. Commonalities or themes recognized in the interviews for the addiction and recovery processes will be discussed further in Chapter 4.

Step 6: Contextualization

Contextualization relocates the phenomenon (in this case, the addiction and recovery process) back in the natural world from the perspective of the participant. In other words, "How have individual biographies and the effects of epiphany experiences shaped these individuals and their social relationships? Contextualizing grounds the accounts of problematic events in the relational world of the subject (Denzin, 1989). Contextualization, conclusions drawn from these interpretations, and future recommendations are the subject of Chapter 5.

STRATEGIES TO ACHIEVE TRUSTWORTHINESS CRITERIA

The nature of qualitative investigation requires a set of criteria that are different, yet comparable to, reliability and validity of quantitative inquiry. Lincoln and Guba (1985) describe the qualitative correlates of these quantitative criteria to be "credibility" (in place of internal validity), "transferability" (in place of external validity), "dependability" (in place of reliability), "confirmability" (in place of objectivity) and "sophisticated rigor" (in place of replicability). Trustworthiness for this study was achieved through several activities.

Credibility

Three activities increase the probability of credible findings: prolonged engagement (the investment of sufficient time to achieve certain purposes, i.e. learning the "culture" and building the trust of respondents), persistent observation (the investment of sufficient time to be able to identify and assess relevant factors), and triangulation (process to increase the probability that findings and interpretations will be found credible) (Lincoln & Guba, 1985).

Prolonged engagement renders the investigator open to the multiple influences - the mutual shapers and contextual factors - that impinge upon the phenomenon being studied. Persistent observation identifies those characteristics and elements in the situation most relevant to the problem or issue being pursued and focusing on them in detail. Both of these activities require immersion into the culture in order to promote

understanding and to build trust. My personal involvement and experience, as well as meeting attendance and exposure to the world of addiction and the recovery process, have been discussed at length elsewhere, and leave little doubt that the criteria for these activities have been met. Instead, the concern in this study would be one of what is called "going native."

Going native refers to the researcher's involvement within a culture to the extent that professional judgment is influenced (Lincoln & Guba, 1985). In the current study, the researcher's (my) perspective has hopefully been clarified by the process of long-term exposure to the recovery process, rather than influenced by it past the point of discernment. A non-chemically induced perspective is a by-product of the recovery process, which is one of the phenomena of interest in this particular study. The recovery process in 12-step programs (i.e., "working the steps") allows the recovering alcoholic or addict an avenue to investigate and take stock of previous behaviors. This process of examination and feedback promotes a clearer account of the subjective experiences with addiction and recovery; a perspective of personal responsibility manifests from a close examination of motives of past actions and associated consequences. In this way, the recovery process supports and values the outside (of the 12-step program) endeavors of the recovering individual. Additionally, because of the complex subtleties and nuances associated and embedded within recovering "cultures" (like AA), my extensive involvement in a number of 12-step programs has provided invaluable insight in helping

to effectively deconstruct programs that utilize the 12-step framework from a feminist perspective.

Another caveat involved the way the women in the current study recounted information during the interviews. Twelve-step oriented programs encourage recovering individuals to "tell their story." Most often, individuals are asked to participate in "speaker meetings." Often, speaker meetings are taped, and the tapes are then sold (at cost) as tools that are designed to facilitate recovery. These stories are told in a specific way that answers three questions: "What was it like?" (using); "What happened?" (what was the event or sequence of events that led you to seek help, etc.); and "What is it like today?" (life in recovery). Since most participants in the current study have "told their stories" many times, the influence of repetition on the way the informants related their life-histories was a concern. Speaker stories share "experience, strength, and hope," with the intent of providing hope to new members; other "issues" (such as abuse) are generally not discussed. However, in an effort to address the concern of "canned" stories, the speaker tape of one of the women was transcribed and offered as a means of comparison with the life-history interview transcription, to illustrate the difference in the way the stories are told. The objective in the speaker meeting tape was clearly directed specifically to the "still suffering addict or alcoholic," and served to rally emotional support, rather than to disclose private detailed personal history information.

An additional concern involved my familiarity with the women that I interviewed. Given the private nature of the issues that surround women and chemical

dependency, I believe the level of intimacy I shared with some (n=3) of these women to be beneficial, rather than detrimental, and served to enhance the trust that is so critical in this process. It should also be noted, though, that I was much less familiar with the last four participants (n=4) than with the initial three (n=3) participants.

Credibility of findings may be demonstrated by participant approval, as the participants are the constructors of the multiple realities being studied (Lincoln & Guba, 1985). This method for establishing credibility is called "member checking." After first level coding, initial impressions and any questions were returned to the participant for further validation and clarification. This process continued throughout the data analysis process. All seven of the participants in this study made themselves available to better ensure that the interpretations of the researcher more closely approximated those of the informants.

Transferability

The establishment of transferability by the naturalist is very different from the establishment of external validity by the quantitative researcher. Transferability refers to providing the reader with enough information to concur that the findings are plausible. Interpretive interaction provides thick description, the descriptive detailed accounts necessary to demonstrate plausible judgments on the part of the interpreter. The current study provides thick description examples from one or more of the participants' interviews that represent each of the themes found in the analysis process. This is the topic of Chapter 4.

Dependability

Dependability was demonstrated in the current study through the utilization of audio tapes and an interpretation team (to decrease perceptual bias), as well as member checking and triangulation (through the solicitation of multiple narratives). The collaborative research team discussed the coherence of the researcher's decisions made during the interpretative process. Categories were identified and discussed, questions regarding specific areas of participants' interviews were clarified where needed, and the themes were taken back to the women for their feedback and validation.

Confirmability

Sophisticated rigor strives to make documentation as public as possible so that confirmability may be performed through an audit trail. An audit trail is similar to a financial audit; it follows the paper trail of memos and journal entries to determine whether sound and logical decisions were made in the research process. The initial coding of the interviews, memos, and journal entries were reviewed by three committee members and by the research team. All materials were made available during research team meetings as the study progressed, changes in the direction of the data were discussed at length and noted, with final recommendations being approved by the research team and dissertation committee members.

SUMMARY

Naturalistic, or qualitative, inquiry and interpretive interactionism were considered to be the most appropriate method for this study. Some of the underlying assumptions and philosophies associated with these methods were described. Steps used for data collection and analyses were outlined. Issues and strategies related to reliability and validity were reviewed.

CHAPTER 4: BRACKETING AND PRESENTATION OF FINDINGS

Introduction

The purpose of this research was to provide a new level of understanding about the addiction and recovery process related to alcoholism and other drug abuse problems among women recovering within the framework of 12-step programs. This was accomplished through the willingness of these courageous women to share their encounters with addiction and recovery experienced thus far into their life's journey. The research question that guided the study was, "How do female addicts recovering from chemical dependency within a 12-step framework personally experience the addiction and the recovery process?" I hope my interpretations honor these women and convey the appropriate meanings given to their experiences. These women are survivors; they were eager to share anything, if there was the smallest chance that others might benefit from their experiences.

Bracketing

Interpretive Interactionism utilizes the researcher as the primary investigative tool (Denzin, 1989) to interpret and convey meaning to the reader. Although I felt drained and emotionally exhausted during data collection and analysis, the process was extremely rewarding. I conducted and taped each interview and transcribed all but three of the taped recordings. The transcription work was very tedious, but the task provided

me the opportunity to listen to the interview a second time and then type and proofread the entire interview again.

The first level of coding began with the next reading. I could hear the participants' voices as I highlighted significant statements and jotted down my initial thoughts. Bracketing leads the researcher to isolate the key or essential features of the phenomenon in question, in this case, the addiction and recovery process. This technique was repeated, working back and forth between interviews and key statements after the interviews were conducted and transcribed. The number of memos and statements from the initial analysis overwhelmed me. Many times, I had to quit working, as I felt that I was "forcing" the data to conform, instead of allowing the data to flow naturally to create thematic meanings.

After reading, coding, listing, grouping and re-grouping meaningful words and phrases extracted from the interviews, some codes seemed to cluster together. Then I would ask myself, "What do these clusters say about the addiction and recovery process?" As patterns began to materialize, the 37 clusters formed 15 broader categories, called sub-themes. Five main themes were then developed from the sub-themes.

The major themes are discussed in separate sections for clarity. However, many of the experiences and the related sub-themes overlap and intertwine with each other. For the participants in the current study, the beginning of the addiction process was not demarcated by the physical ingestion of alcohol or other drugs. The addiction process, at

least initially, really had nothing to do with drugs at all, just as the recovery process was less about ceasing substance use and more about learning to live. Though the themes are separate, the divisions are arbitrary and may be viewed as the continuous evolution of a human life, as adaptive responses developed for human survival.

Addiction and recovery are not independent processes; one cannot exist without the other. There are no definitive beginnings and endings. The cycles of an individual's life experiences flow and blend together as one becomes an extension of the next. Addiction and recovery is only one strand, albeit rather large and encompassing at times, in the fabric of these women's lives. The beginning of the addiction process unfolded as a natural progression in response to life's circumstances, fulfilling psychological, emotional, and physical needs. Just as the thread of individual lives may often appear cluttered and tangled, closer examination of the other side of the tapestry most often reveals a masterpiece. The following sections describe the themes and provide examples of each sub-theme extracted from the interviews.

Presentation of Findings

THEMATIC DESCRIPTION

For explanatory purposes, the five themes are listed below with their corresponding sub-themes and then described separately in the following sections. Even though the themes may overlap, each theme seems to be an essential component of the addiction and recovery process. Theme I, caught in vicious cycles, refers to the abuse

and/or violence, mental illness or addiction displayed by the participants' parent(s) and their efforts to conceal their behavior from the outside world. As the women grew older, they repeated many of these behaviors and exhibited symptoms of the same illnesses seen in their own parents, incorporating these same cycles into the lives of their own children. Theme II indicates what the women endured and how they adapted to the environment in order to survive. Theme III characterizes what happened to the participants as their worlds began to crumble. Theme IV encompasses the initial stages of learning about a new way to live. Theme V embodies the process of becoming whole. The process of becoming whole included the importance of finding other women, in particular, who seemed to provide the women with a level of identification that ran deeper than just recovering from addiction. This process also included the importance of finding other individuals who had found, not only a different way to live without the use of alcohol or other drugs, but a way to recover their souls as well. Transforming moments were instances or a sequence of events that occurred in the lives of the participants that helped them develop faith in Divine Intervention and to overcome impossible obstacles. The culmination of Theme V was the synergy that occurred as a result of the women putting the pieces of their shattered lives back together, to form a whole person much greater than the sum of the parts.

THEMATIC OUTLINE

Theme I. Caught In Vicious Cycles

Sub-themes A. Hurting the ones you love

B. Out of touch

C. Keeping up appearances

Theme II. I Had to Endure What I Had…

Sub-themes A. I had…to adapt

B. I had…no idea what it felt like to be OK

C. I had…little, if any, hope for change

Theme III. Going to Hell in a Hand Basket

Sub-themes A. Jolts of reality

B. The dark night of the soul

Theme IV. Learning How to Live

Sub-themes A. Learning to grow through pain

B. Learning to make healthier decisions

C. Learning to take action

Theme V. The Process of Becoming Whole

Sub-themes A. Members of the tribe

B. Principles for living

C. Transforming moments

The women in the current study were all (though at various stages) recovering within a 12-step program, like AA or NA (See Table 1). All of the women currently attend meetings and are actively involved in a 12-step fellowship. All of the participants have had at least one relationship with a significant other and have had at least one child.

NAME (Pseudonyms)	AGE* (Yrs)	AGE at 1st DRUG USE	LENGTH* of Abstinence+ (Years)	CURRENT* 12-Step Meeting Attendance	EDUCATION
Helen	52	18	15	1-2 times per month	College (some)
Brenda	65	Teenager	21	1-2 times per month	High School
Lori	40	13	16	Once every 2 months	College (some)
Sandy	40	13	10	Unknown	PhD
Vicki	40	14	10	Weekly	College (now)
Jo	58	>12	5	Weekly	High School
Nora	58	19	22	Weekly	Nurse (previous) College (now)

Table 1: Characteristics of Participants.

*As of 2001.

+Abstinence, as used in the chart, refers to the continuous length of time without abusing psychoactive drugs.

Table 1 includes each participant's age at first drug use; however, the reader is cautioned to remember addiction is a process that does not begin with the onset of drug

or alcohol use. For the participants in the current study, the addiction process began with the family of origin. Actually, for at least three of the women, the foundation for the addiction process was laid with the "vicious cycles" that were perpetuated from the childhood experiences of their own parents.

THEMATIC DISCUSSION

Theme I: Caught in Vicious Cycles

"Caught in Vicious Cycles" refers to the cycles of abusive experiences, circumstances, and conditions that surrounded, were imposed upon, and negatively impacted the lives of the participants. These experiences often involved family members, such as fathers, step-fathers, mothers, and/or family acquaintances. All participants reported experiences of sexual, verbal, physical, emotional and/or psychological abuse during childhood, adolescence, and then in adulthood, as well (See Figure 1). Six of the women repeatedly witnessed, and later became victims of, domestic violence. Domestic violence, without intervention, initiated a process that was continued and repeated in the women's own homes as they became adults. The cycles of violence had been set in motion. Consequently, these women, who suffered as children, became by their own admission, the perpetrators they themselves so horribly despised. In this manner, abuse and violence were passed on in the participants' families from one generation to the next in a vicious, never-ending cycle, thus laying the groundwork for the addiction process.

Additionally, substance abuse and/or mental illness were common conditions among the participants' family members. These conditions perpetuated the cycles of abuse and violence, which in turn exacerbated the alcoholism and addiction. All the participants, by definition, were addicted to alcohol and/or other drugs. Mental illnesses often manifested in the participants as well.

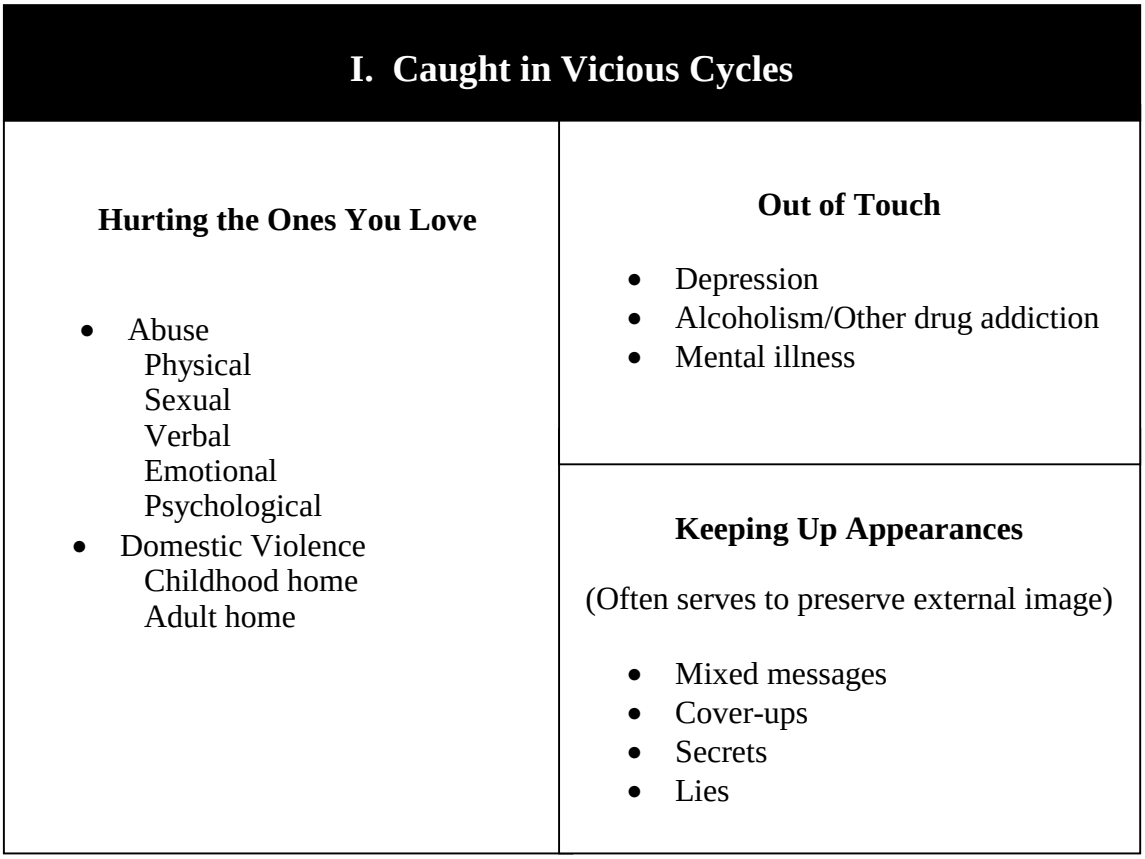

Figure 1: Theme I: Caught in Vicious Cycles.

You might ask, "Why didn't anyone do anything to stop the exploitation and violence?" As small children, these women did not know what to do. The parents

usually lied to cover-up their own unacceptable abusive behavior, keeping up appearances to individuals outside the family and producing confusion in mind of the child. Often the women did not know if they should trust their perception of their experiences or believe the lies the family members told. Frequently, they ceased thinking or remembering anything. Keeping up appearances to the outside world became internalized by the participants and kept the possibility of effective intervention unlikely.

Conditions endured by these women, often on a daily basis, included sexual, verbal, physical, emotional and psychological childhood abuse and exposure to domestic violence. One or both parent's addiction and/or mental illness often compounded and escalated the abuse and violence. These acts were frequently concealed from the outside world through a maze of lies and deceit to protect and preserve a façade of "normality." This need to obscure the truth required that the participants submit to this "false reality" through denying their perceived traumatic experiences, forcing them to believe that their senses were inaccurate and undependable evaluation tools. These abusive circumstances, therefore, contributed to and perpetuated one another. With no available "reality checks," one abusive situation led to another, as well as conditioned the women to repeat these same parenting strategies with their own children. In this manner, individual cycles of "hurting the ones you love," "out of touch," and "keeping up appearances" contributed to the development of an all-encompassing encapsulated, vicious cycle that completely engulfed the women.

Hurting the Ones You Love

"Hurting the ones you love" refers to the abuses experienced and witnessed by the participants as children. All the participants experienced at least one form of abuse during their childhood. All the participants repeated these same cycles in their own adult lives, often by marrying abusive partners, as well as exhibiting the same parenting behavior they had received as children. They unconsciously perpetuated these same patterns by utilizing these models of behavior as adults. Domestic violence in the current study is defined as aggressive and abusive behavior between partners, spouses, or "significant others" and/or the family as a group. Abuse was defined as physical, sexual, verbal, emotional, and/or psychological maltreatment directed specifically at the participant(s) in the current study (See Definition of Terms).

Whether physical, sexual, verbal, emotional, or psychological, all of the women related instances of abuse and violence they had experienced. Although the experiences of abuse varied, the effects were far-reaching and long lasting. For example, Nora's father beat her repeatedly:

> …I have scars where he'd beat me. His favorite weapon was the belt buckle, not just the leather strap, but the belt *buckle*. I got my last beating when I was 18 years old. And it didn't take much - you never knew; it was very unpredictable. You never knew what was going to precipitate a beating.

Sexual abuse is also a common denominator in the addiction process for these women. Five of the women experienced at least one episode of sexual abuse, four of the

five were molested by family members. Nora's father thought "breaking in" his daughters was "his duty":

> …He thought it was his duty to break in his daughters. Sexually that is. The reason we think that my middle sister was not sexually abused was because he wanted a boy. She was supposed to be a boy. She was supposed to be Robert. He always treated her with a great deal of disregard because she was never a boy. He didn't like her. He didn't want anything to do her. And therefore, he didn't love her; so it wasn't necessary for him to sexually abuse her.

Lori, who had been clean and sober for 10 years at the time of the interview, shares memories of verbal and psychological abuse:

> …"I went through my entire life thinking that I was stupid. My dad would call me a bird-brained idiot, or it was either, "Why don't you think sometimes?" or "That's what you get for thinking!"

Domestic violence was frequently seen and experienced by the participant as a child, and often this cycle of abuse materialized in their adulthood homes as well. Sandy described a scene from her childhood in which her father's alcoholism contributed to family violence:

> ...I had a lot of nightmares about my father's drinking. I remember seeing my mother choke my father. When he passed out, she thought she had killed him. And I was present when my dad totally destroyed our living room and threatened to turn over the piano that mother treasured. I watched the whole destruction.

As Sandy grew older, she repeated this cycle by bringing violent men into her own life:

> …Got myself into another abusive relationship, very abusive. (Inaudible.) You got the picture…So, there we are, me hanging out with Carrie and suddenly working on my masters. By then I had two different lives. It's like, I'm this graduate student until 3:00 in the afternoon, then I'm at this porno theater until 1:00 in the morning. And that's how I was living. Living with this insane, abusive, violent drunk.

Jo, who suffered abusive atrocities in her childhood, also brought domestic violence into her adult relationships. Her first husband tried to kill her and their son by throwing acid on them:

> …He turned out to be one of the first of the crazy ones; very abusive, wanting to throw acid in your face…I am very sure that he has disappeared some where…we had guards around our house and after that night that he tried to kill my son and I - he vanished. I never asked questions. My life continued like that…Met another abusive man - an escaped mental patient (ha) been locked up in the violent ward for 28 months - and I married him 6 months later. The cycle of the abuse system - the flowers, the candy, keep you from your friends - and two weeks into the marriage, boom, you're getting the hell beat out of you.

Brenda was sexually molested throughout her childhood by her mother and abused physically and emotionally by both parents. She resented her father for not realizing what was happening or refusing to take any action to prevent it from happening again:

> …for instance, she would make us all get up in the middle of the night and clean house. It was an annoyment. But when I got grown, the thing that really puzzled me is why my dad allowed her to do that because it really doesn't surprise me too much that Mother did that. And so the thing of it is, I thought, well, why didn't Dad just say, "Look, these kids got to go to school in the morning. This is ridiculous. Go back to sleep. They are not going to get up and clean." But he never did that. And today, I would bet you anything, he would say it never

> happened, that Mother never did that, she never got us up. Because a lot of that went on later when I asked him why. Oh, well, that never happened.

As an adult, Brenda married an abusive partner and survived domestic violence. Though one daughter has since passed on, all four children were present when her husband became violent in the following story:

> …And he would hold - take a shotgun and hold it on the whole family….anyway, he finally started drinking. He got to where he'd constantly smell like liquor and buy gallon bottles at a time. I remember sitting in the living room one time and - or in the den. He had a shotgun there and just made us all sit there.

Out of Touch

The persistence of vicious cycles suggests an underlying or additional impediment that supports and exacerbates abuse, neglect and violence. Indeed, the women, without exception, had at least one parent who suffered from alcoholism/other drug addiction, and/or some other type of mental illness. The parents' conditions left the child without nurturing or guidance, and with no opportunity for developing an emotional attachment to a loving, caring family.

Helen's mother became depressed after the death of Helen's father; his death initiated what appears to be a mental breakdown or depression. Even though Helen's mother's depression may be a "normal" response to the death of a spouse, its continuation nevertheless prevented Helen from having a mother who was "available" while she was dealing with her own grief and the loss of her father. Helen described it this way:

> …And when I was 14 years old he died of pneumonia. He was 35 years old. He was allergic to penicillin; that was the only antibiotic there was…My mother was real out of it for a long time. When my dad died it was so devastating to her, that, she was really out of touch. She was just so disconnected and detached. And she would go in the bathroom and close the door and cry.

Sandy's parents were also "unavailable" as her mother suffered from depression and her father was a habitual gambler and alcoholic:

> …well, really - I've been told this, I don't have a lot of memory of this, but during my first year and a half of life, my mother was very depressed and didn't have much to do with me. My dad was an alcoholic…gambling and how that affected the things in my house… that was about when my father's drinking got to its worst.

Nora's "out of touch" father was mentally ill, though his condition was never discussed openly. She deduced:

> …My dad was designated 4f** in the service, which has always been of great suspicion to the rest of us. Mother didn't even know why he was classified as 4f- but we think it was because he didn't pass the mental exam. He was extremely abusive…

**unfit (mentally) for military service or duty

Nora's father did not believe in alcoholism, yet he was an alcoholic:

> …Dad did have a problem with alcohol. I remember times being hungry as a child, but dad always had his alcohol. He never believed in alcoholism and never believed that I was an alcoholic. He didn't believe in child abuse, either.

Like her father, Nora became an alcoholic. She remembers that both she and her husband were deep in the throws of alcoholism when she was abusive to her own children:

> …Those kids had to get up and get themselves to school because I was already at the café. They had no one there to greet them when they got home because I was either in the bar, or I was at the café…and I thought I was teaching them to be responsible. They did all the cleaning; Elizabeth raised the boys. She couldn't control them; hell, I couldn't control them. How did I expect this little girl to do that?…if CPS (Child Protective Services) had been involved then like they are now, they would have taken probably all three of the kids away at various points. I was just as abusive as my father was - maybe even worse so - although I wasn't sexually abusive to the children - I certainly was verbally and physically abusive and neglectful - and that's a part of my story that I am not very proud of, but it's also part of the story that got me to where I needed to get to.

Parents who are "out of touch" for one reason or another, whether unable or unwilling to admit their own shortcomings, continue the addiction process by teaching their children (the participants) the same parenting techniques through modeling destructive, abusive, and unhealthy behaviors. Whether or not any of these behaviors are hereditary or learned is beyond the scope of this study. However, the experiences of the participants as children, and later as parents, suggest that these patterns are transmitted from one generation to the next, perpetuating this vicious cycle.

Keeping Up Appearances

Vicious cycles are hidden and maintained by "keeping up appearances." "Keeping up appearances" refers to efforts of the perpetrator(s), particularly family members, to conceal their transgressions of abuse and violence from the outside world

through denial, lies, and other cover-ups. Jo grew up in a fairy-tale world - on the outside anyway:

> …I came right from a fairy-tale princess - I came from a very wealthy family. If you had seen how we lived you would have thought I was the luckiest female child on earth. But inside, behind the closed doors, at night was when the hell began. I don't know what "Mommy Dearest" did in the movies, but my mother would throw bricks at my back and beat me - and when I was a teenager, she would make me get down on my knees and beg to go out - in front of my friends."

Keeping up appearances perpetuates abuse and violence through concealment of these acts and produces confusion, especially among children who have few "normal" experiences with which to compare their own. The community is unaware of, and the child does not or cannot recognize, the abuse. Therefore, the perpetrator is shielded from community accountability for his/her participation in offensive and violent behavior. When these types of experiences are denied and closed-off from the outside world, survival of the individual depends on learning to adapt to the environment.

Nora exhibited similar cycles of abuse through "keeping up appearances" with her own children:

> …So between beating holes in the walls and beating the kids when I was at home, and going to church on Sundays - singing in the choir, and being part of PTO (Parent-Teacher Organization) and everything that was going on at school, and the Chamber of Commerce and the Jaycees…

Mixed messages in the current study refer to incongruent verbal and physical messages. These types of messages seemed to create inner conflict for the participants.

Inner conflict influenced the messages they told themselves about themselves. Ultimately, mixed messages fuel the addiction process by negatively defining the women's personal frames of reference and the way they perceived others. In effect, their frame of reference and source of validation became externalized. Not only were their parents out of touch and thus incapable of attending to their children's emotional needs, they were often overly concerned with the opinions of others, as shown in "keeping up appearances." According to some participants, those opinions took priority over parental concern for the participants' personal welfare. Vicki's personal substance use was a source of distress for her mother, not out of concern for Vicki's welfare, but because Vicki's behavior reflected poorly upon her image as a parent:

> …I remember being really bitter with my mother because the biggest problem she had with me smoking pot was that it made ***her*** look bad. You know when you're 14, you start figuring stuff like that out. It disgusted me, you know. It really bothered me – It wasn't a conscious thought, but I thought they cared more about that (their image) than they did about me, but I sure got the feeling that was true.

Emphasis by the parents on external appearances resulted in a lack of concern for the child's internal condition and added to the participant's feelings of low self-worth. Placing emphasis on the outer appearance ignored any underlying problem that may have caused or added to internal conflict manifested in the participants' addictive behavior. In this manner, the inner turmoil experienced by these women contributed to the addiction process.

The process of finding a solution that could reconcile the participants' self-perception and their inner conflict became necessary for survival. The women, who often had no recollection of sexual abuse, also had no way to effectively resolve their inner conflict and could not expect help from "outsiders." Three of the women attempted suicide for reasons beyond their realm of awareness. The participants had to survive in a hostile environment, trapped with internal feelings of turmoil and dysfunction, and with no recognizable healthy alternatives, they could only adapt to their surrounding circumstances. Theme II describes how the women in the current study experienced this adaptive process given their surrounding circumstances and the few tools with which they had to work (See Figure 2).

Theme II: I Had to Endure What I Had…

The women had to endure seemingly unbearable circumstances. They were forced to adapt, consciously or not, to their environment and to the inner turmoil that it had created. "I had to endure what I had…" meant they had to adapt, with no idea what it felt like to be OK and with little or no hope for change. What happens when someone is forced to survive a hostile environment and the only tools they have been shown are destructive? Instinct is to live, and to live, the women tried several strategies to escape abusive situations in order to survive. These approaches included physical and/or mental escape, pretending or ignoring reality, and if these did not work…trying to change perspective. The women were filled with feelings of inadequacy, shame, guilt and

remorse from being victimized again and again. These women had little hope that their plight would improve.

<table>
<tr><th colspan="2">II. I Had to Endure What I Had…</th></tr>
<tr><td>I Had… to Adapt
Physical escape
Runaway, hide, get away,
Suicide attempts
Mental escape
Memory loss/dissociation
Mental breakdown
Deny
Pretend it doesn't exist, ignore
Change the way I feel
Alcohol, other drug use, sex</td><td>I Had… No Idea What It Felt Like to Be OK
I felt shame
I felt unworthy
I felt undeserving
I didn't fit in
I felt "apart from"/not a "part of"
I compared the way I felt on the inside, to the way others appeared on the outside.</td></tr>
<tr><td colspan="2">I Had… Little, If Any, Hope for Change
Little, if any, power
Little, if any, control over bodies or lives
Few life options</td></tr>
</table>

Figure 2: Theme II: I Had to Endure What I Had…

I Had…to Adapt

Adaptive responses are those reflexes, conditioned responses, or strategies utilized to carry the individual through life as long as those actions function or fulfill the goal of continued existence. Escaping pain in order to survive was the best they could hope for at the time. Many of these responses were developed as a reaction to traumatic experiences and were often not part of the conscious mind. Therefore, even though the

strategy was utilized, the participant, in this case Jo, did not become aware of the "why" until much later:

> …I was functional, I didn't know why at the age of 13, as a teenager taking 200 aspirins and walk downtown wanting to kill myself; or sitting in the car, at your own birthday that your godmother made you a cake and a party for, in the heat with the windows and doors locked at 6 or 7 years old.

After years of therapy Jo discovered why she had felt dysfunctional and why she had been so afraid of the dark. She had been sexually molested, had witnessed her mother trying to stab her step-father, had been given drugs to sleep, and then told (by her mother) to "pretend it didn't exist."

> …It was traumatic - *I hid in the closet* for many years - I set up camp there, had my things set up there. My mother would give me Seconal at night, and put my hands like in a casket over my chest and say, "Just go to sleep...*Pretend you're asleep*," then all hell would break loose, and she would chase him with a butcher knife…it was all very pleasant (sarcasm). It scarred me - Being a survivor *you block that out until you can handle it.*

As previously mentioned, adaptive responses for avoiding fatality may be utilized consciously or unconsciously. Physical escape was one solution. Mental escape, characterized by dissociative states, memory loss or mental breakdowns, was another solution. When Brenda was too young to physically "get away" from her mother she escaped mentally by hiding her "self":

> …I'm real aware that when I was about three or younger I hid my real self behind my belly button to keep it from being - I think I thought Mother really wanted to kill me. And now…I think that I was probably right about that. I don't think she

> wanted to physically kill me, but I think that she thought I was very precocious and that she wanted to kill that aspect of my personality. So I - she did that. And that's why sex and stuff I would never let a man touch my bellybutton…And I didn't know why, though. But I just knew that I never let anybody touch my bellybutton. And then later, I think that's why I got fat, too, because that was a way - another protection to keep my real self.

As she got a little older, she could physically "get away" from her mother:

> …And I violently disliked my mother when I was a child. She would sleep with me at night sometimes and I'd kick her to make her get out of bed. Later, in therapy, I realized it had something to do with that, but as a child it just -- I just thought I didn't like the way her body felt and stuff. I didn't want her near me. By then, I was six and I could get away from her so I did.

As a teenager, she suffered a mental breakdown:

> …I just -- I had a conflict. And then I -- when I got out of school, I think I had a nervous breakdown probably when I was about 16. I quit learning. I quit - I mean, I did learn, but it was like through a fog or something. I quit thinking.

For those women who could not escape mentally or physically, suicide became a viable option. Suicide may not seem like a survival strategy per se; however, suicide is a way to stop the pain. Nora attempted suicide on numerous occasions, or, as she put it, "every time I turned around." On the surface Nora's attempts may seem to be in direct conflict with survival, but, for her, suicide was a way out. It was a way that she no longer had to think about being abused or beaten:

> …I didn't start drinking until I was 19, but when I was 16 I tried to commit suicide. I took three-quarters of a bottle of aspirin. I lived for three more years without any kind of anything to resolve all of that junk that was going on inside

> of me. I was caught between being with this good bunch of kids, thinking that I belong with the yucky bunch of kids, and that conflict that I'm having prohibited any kind of self-worth or self-esteem; and the secrets and all of that is mulling around in there - I just don't know if there are words to describe all that emotion.

Nora found freedom and relief from her state of internal conflict the first time she drank alcohol. For Nora, alcohol proved to be, however temporary, a measure that probably saved her life:

> …Anyway, we were there and somebody brought in 90 proof Everclear - and I got drunk. And not only did I have *one* of those, I had *two* of those. I went into a blackout and all I remember is: **I… FELT… SO… FREE.** I can still feel it. All that internal stuff was gone. And man, I don't know what happened that night except that that was the most incredible feeling that I have ever experienced then or since in my entire life.

Many of the circumstances the women had endured made alcohol or other drug use a welcome relief. This strategy worked well for all of the women for a long time. All the participants utilized this strategy very effectively, at first. Eventually though, at one point or another, this solution became a major problem, but in the beginning, the instantaneous results were glorious! All problems, conflict and inner turmoil seemed to vanish and became instantly replaced with relief, ease and comfort that they had found in an altered state of consciousness produced by the use of a drug. Nora described how drinking made everything OK - just for a little while:

> …In fact, the only time that I did fit in my own skin was when I had a drink. And whatever act I committed prior to drinking or after drinking, I still didn't fit into my own skin. But somehow, for a few minutes, the alcohol seemed to ease that discomfort.

Drug use provided personal power to these women. This "feeling" of power was a novel liberty, the possibility of which was never before even conceivable. Brenda paints a vivid picture illustrating the impact and effectiveness of utilizing alcohol as a strategy for regaining power. More than merely facilitating survival, she associates the feeling of power that alcohol produced within her, with her spirit or spirituality:

> …this would be the greatest spiritual awakening I've ever had in my entire life. After about the second or third drink, I had gone to the bathroom and all these years we were married, I had this little poem I'd say to myself: "For all your days prepare and meet them never alike, and when you are the anvil, bear; and when you are the hammer, strike!" And so I'd think, "Well, I'm the anvil, I'm the anvil. I'll put up with this, I'll put up with that." And I remember being in that bathroom stall and thinking - that thought would hit me and I thought, "Baby, I'm a hammering now!!"

Many of the women used sex as a way to change the way they felt, to feel *better*. Sex often became confused with love, acceptance, and intimacy. While this is commonly called "acting out," Nora explained it like this:

> …Plus the fact that we've got a lot of that sexual abuse stuff that's not ever been recognized, talked about, even as an idea; yet the lower I feel about myself, the more I need someone else to make me feel good…. I think that was true, not only in acting out from the sexual abuse, but also was the only way I had any control over my life…And I know today, because of the sexual abuse, the sexual promiscuity of course, I probably did not pay attention to what was good for the body; I kept feeding my self worth through that act. You know, through my experiences of working with women, I have noticed that's a phenomenon that seems pretty universal - it's so bizarre - logic would say the thing that screwed you up would be the thing that people would go away from, but that's not the way it is with abuse - it seems like an attraction, a fatal attraction - how sick.

Lori was raped by a friend's older brother when she was about 14 years old. This experience contributed to her alcohol and other drug use, as well as to her sexual promiscuity:

> …her boyfriend and her brother knocked on the trailer door and they were really drunk. To make a long story short, he raped me - but I didn't know it at the time I mean today I know that's what he did. I kept saying no, no, no, no, no, and he did it anyway. And of course I can't tell my parents, you know, ladies don't have sex before marriage and all that… That was probably when I really started using alcohol and drugs on a regular basis. That definitely pretty much changed my life forever. So after that I figured, you know, "What the hell, I'm not a virgin anymore, so I'll sleep with whoever I want to." It was the '70s, and that was how I learned to find love and acceptance and intimacy, I thought, was through sex.

The process of adapting to traumatic experiences, except for the time the women were "high" or "drunk," left them with feelings of guilt and shame that riddled their confidence with doubt and left them with feelings of inadequacy.

I Had…No Idea What It Felt Like to Be OK

"I had no idea what it felt like to be OK" was an overall feeling of insufficiency or failure that internally set the participants apart from other human beings in a negative way. These feelings of inequality also perpetuated submission and subordination to others. The abusive and violent episodes experienced by the women combined with their lack of support added to the participants' individual feelings of guilt, shame, and low self-esteem. Vicki talked about her parents' inability to show affection:

> I don't think they knew how to be affectionate; you know to make you feel loved and okay. I've talked to my sisters and that's kind of what they remember, too.

Many of the women quoted a familiar 12-step program slogan: “I compare my insides to everybody else’s outsides.” Harboring internal feelings of guilt, shame, and unworthiness predisposed the women to assume they never “measured up” to the way those “normal” people looked on the outside. Utilizing a distorted external frame of reference made finding a way to fit in or be a “part of” the human race difficult for the participants. Nora’s “secrets” negatively impacted the way she felt about herself:

> …Today I realize how insecure I was, and I didn't have any self-esteem; probably "the secrets" had some influence on that, and I was very ashamed of my parents; it may have been an appropriate emotion.

She also acknowledges how her childhood experiences affected the way she perceived her capabilities:

> …What was going on was that I was carrying all of the dysfunction from home, as the hero child that was part of my role to do that. And I remember mother saying to me that I had common sense; and I did not think that she meant that as a complement; I thought she meant I was stupid. So I thought I was stupid. So I went through life and I carried that out.

To continue to live amidst abusive conditions with internal conflict required some sort of strategy to navigate through the treacherous waters of life experienced by these women. Limited choices compounded by abusive events promoted their belief that control lies in the external world. Thus, the women in the current study began their struggle for external control, confusing it with personal power.

I Had…Little, If Any, Hope For Change

The women in the current study had very little actual power to change their external or physical circumstances. As children, they were abused and traumatized; many of them had little if any, control over their bodies or their lives. Exposure to abuse, including anything from emotional unavailability to active overt violence, made it difficult for the women to discern the truth about what was really happening to them, including lies and deception. As adults, the women repeated these cycles of domestic violence by often marrying an abusive and controlling partner. The role was familiar. Yet again, fear of reprisal combined with internal feelings of guilt and shame led the participants to believe they had few life options and no thought or hope for escape. Whether rigid or chaotic, the end result was an environment that supported oppressive conditions that gave the participants limited options even in their day-to-day choices. Sandy describes her life after her father quit drinking. Whereas her life prior to this had been filled with chaos, it went from one extreme to the other:

> …That's kind of what my childhood was like as far as I can recall. And it went from being really totally crazy and insane to when my dad stopped drinking to very rigid. Things - when I say rigid, it's things like at the dinner table there was always a television. And I sat between my dad and the television. So I had to eat dinner leaning back so he could see the TV. We weren't allowed to talk at the table because he was watching TV. And all the rules; I got in trouble if I threw a sweater on my bed and left it there. It was real strange, rigid household. And that was very different from the very chaotic household prior to then.

Similarly, Lori's parents had strict rules, and she was not allowed to make many of her own decisions. She described the rules of "don't" that existed in her household like this:

> …Our household was very rigid; we had strict rules, and my father had a bad temper and later so did my mother…So we had these rules: ladies don't cuss, they don't drink, don't smoke, they don't wear red fingernail polish, they don't wear short skirts, they keep their legs crossed, they don't have sex before they get married, they don't get angry, and they always smile at any cost.

Women were aware of explicit directions of what NOT to do, but very few were given instruction on what exactly WAS proper. The women also endured oppressive conditions that limited their choices regarding their careers and their future. For example, Nora's mother often worked to put food on their table, but according to her father who spent the food money on alcohol, "women didn't work." Nora wanted to be an English teacher, but because her decisions were made for her, this was not a realistic goal.

> …The guidance counselor decided I wasn't college material. Partly, I'm sure, because of the lack of psychiatric stability, and partly because of my grades; they were B's and C's. …And so they decided (they meaning Mother and the counselor) that I should work for a year, and then if I was still interested, maybe become a practical nurse… So it really wasn't much of a choice about going to college; there wasn't money, and there definitely wasn't emotional support to do that. So the idea of me being a teacher was just not an option.

The chaos and rigidity encountered by the participants, when added to their inability to distinguish the true from the false, created a faulty mechanism by which to

accurately assess their circumstances. These messages dictated the participants' inner core beliefs of the self, thus dictating how the women felt about themselves. The painful beliefs of worthlessness necessitated a further separation of the inner self from the outer physical world so that they could hide their feelings of guilt and shame. In this manner, the façade of well-being and sanity was temporarily supported and preserved.

For change to occur, some portion of a system must become unstable. For the participants in the current study, "normal" functioning became impaired and the techniques that they had previously utilized no longer served to promote survival. Drugs served the women in the current study very well in the beginning of the addiction process, but as the addiction process progressed and as jolts of reality became more common, the women began to realize that their solution had become a problem in itself. Not only were they faced with finding new ways of dealing with emotional pain, they were also faced with physical withdrawal reinforced by habituation of the behavior. Chemical dependency had to become more of a problem than re-living even their most horrible past experiences. The participant's substance abuse began to cause more problems than it solved, AND it no longer provided any type of relief from the original maladies it was employed to escape.

Theme III: Going to Hell in a Hand Basket

"Going to hell in a hand basket" was a transitional time when the addiction process began to unravel, making the recovery process a more appealing alternative. "Going to hell in a hand basket" began to occur when the major survival strategies no

longer functioned to sustain life or "keep the system going." Several areas of the women's lives were affected as more and more "jolts of reality" were accumulated. The lives of the participants' children were also endangered. Often their children were removed, or were threatened to be, from their care. All of the women cited near-death experiences from substance abuse or violent episodes, as "jolts of reality." The dark night of the soul was that place in the pits of hell at a time when nothing, "no-thing," no person, place or thing could help alleviate the pain that had been acquired, caused and endured over the years (see Figure 3).

The addiction process began to unravel and, although painful, necessitated at the very least *consideration* that something had gone terribly awry. This allowed a tiny "crack" in the participants' shell for the recovery process to take root. Lori abstained from substance use while she dated a young man who did not drink or use other drugs. During this time period, she quit using drugs for about 18 months. Although she had no way of knowing at the time, in retrospect she believed she had "crossed over that line" into addiction from which there is no return:

> …Today, I truly believe that the day I got high, was the day I crossed over that line. I believe that because I had quit for a year and half - and I never even thought about using; I couldn't quit after that. *My life went to hell in a hand-basket.*

III. Going to Hell in a Hand Basket	
Jolts of Reality • Can no longer keep the personal problems out of the public arena -Personality changes (Jekyll/Hyde) -Jail -Children • Overwhelming fear • Overwhelming pain • Near death/death of close family member or friend	**The Dark Night of the Soul** The strategies for surviving one or more pieces of life become ineffective, making life intolerable and impossible. • My solution became my problem • Could no longer run, hide, ignore, deny reality • Alcohol, other drug use provides no pain relief and makes living circumstances more difficult

Figure 3: Theme III: Going to Hell in a Hand Basket

Jolts of Reality

As life became more and more out of control, many of the women experienced personality changes, jail, all-consuming fear, or attempted suicide. This made it increasingly difficult for them to sustain or shield their personal lives from public scrutiny and intervention. Emotional pain, death or near death of family members or close friends, marriage, and separation or divorce were also reported to occur more frequently. These events sometimes occurred alone, but most often, as was necessary to effect a major change, several tumultuous events occurred simultaneously. For four of

the participants, jolts of realty involved their children. For Sandy, endangering her daughter's life was the event that initiated her sobriety:

> …And I proceeded to get even and took the kids to a sitter. And so he was up in Oklahoma and I start drinking. And then I start doing cocaine. And I'm really without a clue what I did for 24 hours. But what I do know is that somehow or another, I drove myself in that condition (inaudible) that leaving the day care in the middle of the night - it was one of those 24-hour ones - I fell down the steps holding Annie in my arms. I know I did all that. And that was the actual experience that got me to turn sober. I just - I couldn't do it to her.

Nora's daughter heard a presentation at her school about alcoholism and came home to confront her mother:

> …This alcoholism counselor came to the school and talked to these kids, to these great kids about this family disease called alcoholism. And this little kid had a light bulb go on in her head because all those skuzzy things he was talking about were going on in her home. It was like the last piece in a puzzle to her. She came home, and I can still see her standing there with those big bright blue eyes and curly red hair, and she said, "Mom I hate you when you're drunk!" And my solution to that was to slap her across the room for not showing me very much respect. That was the first intervention (she cries). I'm one of those people that believes every intervention works, it just doesn't look like it does at first. It didn't stop the affairs, it didn't slow down the drinking, it didn't quit the beatings, it didn't quit the holes in the wall, but it left a lasting impression.

For Vicki, attempted murder and jail were jolts of reality:

> …I assaulted my roommate. I was lucky that I didn't really hurt her bad. She called the police, and anyway, I got thrown in jail. And since I was on probation, my officer revoked my probation. And although I wasn't trying to kill her, that scared me. It was just the whole horrible thing, and I woke up. It was like, "I can't drink." It just, like slapped me, "I can't drink." I almost choked this woman to death, and "I can't drink," and it's stayed with me.

All of the women had "blackouts" they associated with the Dr. Jekyll and Mr. Hyde analogy. Jekyll/Hyde was also an analogy that paralleled what was happening in their lives, as Dr. Jekyll took over the personality more often, making it more difficult to keep the personal problems associated with drug use out of the public arena. Lori talked about the way she had *become* Dr. Jekyll and Mr. Hyde at other times:

> …I had become Dr. Jekyll and Mr. Hyde. I went to my classes during the day - always high; and I started hanging out less and less with Jacob - they didn't do shoot drugs - they would have been appalled. And I started hanging out with this guy who was a dealer for the Banditos. He taught me how to play pool, we went to after-hours bars, and I started hanging out with the "old ladies" of the banditos who were topless dancers. Now the Banditos do not approve of shooting drugs - but a lot of their girlfriends did it anyway - and if their "old man" ever found out, they would get the shit beat out of them. I went to school with all these jocks - because I was a PE major - I was in an honors sorority, and I played basketball on an intramural team, and my drinking and my drug use kept getting worse. My arms became black and blue and sore, and I couldn't wear short-sleeved shirts anymore - even in the summer. So between learning the façade of putting on a smile for the world as a teenager, ignoring all the violence in my life (if I wanted to stay alive) and exchanging sex for drugs, and living two different lives; I learned to be a chameleon; whoever I was with, I was like them. I remember making a conscious decision, I closed my eyes and I built this wall 3 feet thick and 10 feet high all around me, and I decided that no one would ever hurt me again. And I lived behind those walls, and they protected me. I literally walled myself off from the outside world. I used the drugs to stay behind those walls so I could forget, so I didn't have to feel anything.

Helen recalled the night of her high school reunion that vividly illustrated the unpredictable and radical changes that had begun to occur in her personality. The memory loss or "blackouts," having no recall of her behavior and wondering what she had done while she was drinking, had become problematic, exacerbating the split personality:

> …and we picked up a six-pack and I don't remember my class reunion. I don't know if I was Dr. Jekyll or Mr. Hyde. I don't know which one. Some of them sometimes still speak to me - so maybe it wasn't too bad.

In addition to the unpredictable personality changes and blackouts that occurred when she drank, Helen also talked about the all-consuming, illogical and overwhelming fear that gripped her on a daily basis:

> …When I'd go in the grocery store - I mean I was consumed with fear. And, which is all part of the disease. And I would be in the grocery store and I would think, "I hope the bill is 'thirty' because I can spell 'thirty'; I can probably spell 'forty', but I don't know if I can spell… I would have to look up to see Brookshire's written somewhere so I could write it out. I was just full of fear.

Vicki described her fear as "panic" or "anxiety attacks":

> …I was having a lot of paranoia and probably anxiety attacks - but I didn't know that at the time. I didn't know what was going on. All of a sudden everything would just get, kind of - I would get tunnel vision and I would feel like something horrible was about to happen… I remember standing in line - the first time it ever happened to me. All of a sudden it was just panic, you know, the tunnel vision - and I was thinking, "The minute I step through that metal detector something horrible is going to happen." I'm managed to get through it, but I felt like I just wanted to runoff screaming. I didn't but - things like that - they just kept progressing.

Nora talked about fear and rage:

> …And it was about that fear of getting caught, fear of being found out. About not knowing how to be genuine; it certainly caused discomfort. And the rage - I was a very rageful person…

In retrospect, the participants had begun to realize that their drug use had become problematic long before they could admit it to themselves or to anyone else. As their personal lives became exposed, however so slightly, this "crack of light" that pierced the darkness of their secret world was too much to bear. Jo had become completely dependent on her son before she realized she was going to die:

> …as time marked on, I lost a couple of years in there - and I knew I was going to die. I knew that. I didn't even weigh 90 pounds, and I never ate. I just lived off whiskey and Schnapps' and the drugs… My son lived with me because I couldn't be left alone…I set the kitchen on fire two or three times and the bedroom once.

Lori's self-loathing was no longer suppressed by alcohol or other drug use:

> …Now I was really fucked up at this point in my life - I hated me so much I couldn't stand to be alone. To be alone meant I had to be with the person that I hated the most in the whole world - and I couldn't stand to look at what my life had become.

Their lives became increasingly "out of control," and they were forced to examine the extensive damage caused by their substance abuse problem. There is nothing to compare when a person "hits bottom," as they say in 12-step meetings. For the participants in this study, though, the dark night of the soul seemed a much more appropriate description.

The Dark Night of the Soul

The jolts of reality had pierced the women's armor, forcing them to re-evaluate previous approaches or current survival strategies. Running, hiding, ignoring, denying or altering perceptions became ineffective, and life became intolerable and impossible for the participants as they began to experience what can only be called the "dark night of the soul." In fact, the main solution, the women's drug use, was causing *more* pain than it ever took away. When death was imminent and there seemed to be no way out, the walls were closing in and there was nowhere left to turn, that was truly the dark night of the soul. The women often thought, perhaps accurately, they were going insane. One of Jo's experiences near the end of her drug use illustrates this insanity and demonstrates just how much of a problem her solution had become:

> …After that…I..the drinking…everything had gotten out of hand. I remember detoxing in a closet, not even knowing what I was detoxing from. I was coming off alcohol, methamphetamines - I had been shooting those for nine months; you name it, like strawberry, chocolate, vanilla…whatever. My next-door neighbor came in, she was kinda of like grandma, she said it smelled like a urinal because I was in that closet - the withdrawals, the mess, losing control and everything that you go through. So I went to Trens (psychiatric ward in Houston) and said, "I think I'm crazy; can you lock me up?" And they said, "You're not crazy - you're sick." They said, "Call intergroup," and I said, "What's that?" And they said, "Alcoholics Anonymous." That was in 1978. I got into AA - it took me two years to get sober and clean. [Author's note regarding the consistency of Table 1: Jo had several medically-related relapses (becoming addicted to a prescription medication, such as morphine, that is related to a medically-necessitated procedure) after 1980].

Lori tried every possible way to use drugs successfully - to no avail. Having been married less than a month, her dark night of the soul was preceded by the knowledge that death for one of them was eminent:

> …and I got on my knees in middle of the floor in this big old house and I said, "God, if you're really there, you know I can't handle much more of this. One of us is going to die if we don't get clean and I don't want that to happen. I've tried everything I know to quit using and I can't, but if you can do a better job, then I'm willing to give my will and my life to you. And if you're really there, then please bring him home safe."

Retrospectively, Lori characterized her experience with the "dark night of the soul," contrasted with how she felt ten years later:

> … I don't know if the gates of heaven will swing open to let me in, but I know the gates of hell have opened and let me out. And today that's a pure miracle.

Brenda attended 12-step meetings and Al-Anon on and off for several years before she took her last drink:

> …And then May 31st, 1980, I just had one drink of alcohol that day, but I felt like I was sliding off into something I could never recover from. That was my very last chance. And that's my sobriety date.

For Brenda and Lori, the Dark Night of the Soul corresponded to the date they quit using alcohol or other drugs. Abstinence (not using alcohol or other drugs) is not a necessary component of this category, and, for some of the other women, this did not occur until later in the recovery process. For other women, they had yet to learn that

chemical dependency was a major contributing factor and had become a large part of the problem.

Theme IV: Learning About Living

The women in the current study had much to learn about living. At first, navigating through life was extremely difficult. Many of the women had been told during the course of adapting and surviving in their world how NOT TO behave. However, now in addition to tremendous emotional and often physical pain they were faced with finding new ways TO live. Sandy continued to experience suicidal tendencies even after, or especially after, she got sober. This drove her to seek therapy in addition to 12-step meetings. "I went to therapy, I went to meetings. I was suicidal. I'd been suicidal for a long time. So I had to go to a lot of therapy."

Growing through pain, learning to take action, and learning to make healthier decisions are sub-themes that closely overlap and are intertwined with one another. The participants' were shown that they *could* grow through the pain and the experience was not going to kill them, even though they often thought it might. Learning how to go through agonizing experiences without the use of drugs to numb the pain was tough for these women. Learning about living included learning how to take action in the midst of adversity and in spite of their fear (see Figure 4). It also required learning how to make healthier decisions as the addiction process lessened and the recovery process gained precedence. In Theme IV, the women learn how to "do" in life. Later, in Theme V, they learn how to "be" in life.

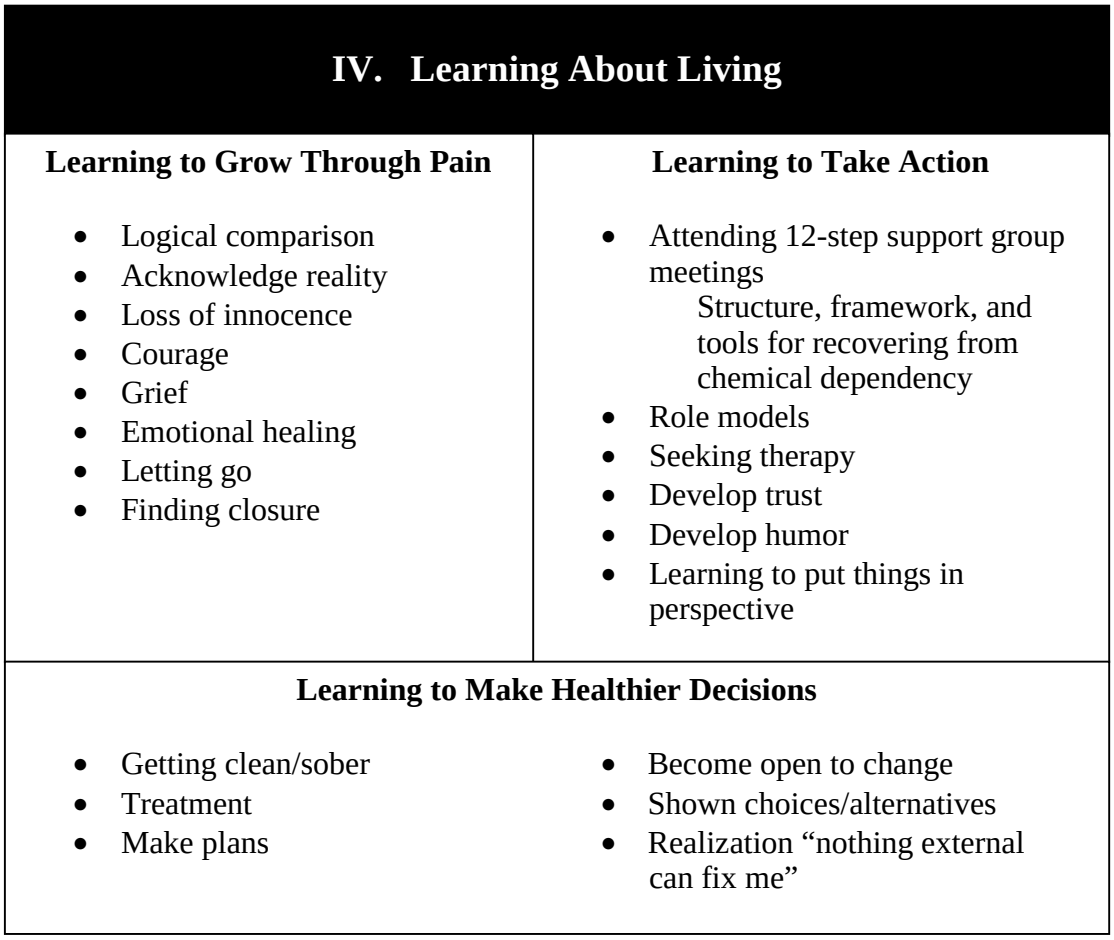

Figure 4: Theme IV: Learning About Living

Learning to Grow Through Pain

Facing reality and learning to grow through pain without using drugs requires courage. They had to face the truth about their reality, about the things that had happened to them and the things they had done because of what had happened to them.

As the women acquired new information, they began to utilize other ways of responding and dealing with life's circumstances. For example, "logical comparison"

was a component of the growth process whereby Brenda came to realize that her mother's strange behavior did not have anything to do with her. Instead she came to realize that "something was wrong with (her) mother." After having children of her own, she compared what she would do with how her mother had behaved:

> …She would sit around in a dress with no underwear on and flash. When my kids got up a little older, I thought, "Why would Mother do that?" Because I thought, "There is no way I would do that to one of my kids. That's the first time ever, I questioned that there might be something wrong with my mother.

The growth process was sometimes painful and contained both positive gains and losses. For the participants, growth involved acknowledging the truth or reality of the circumstances in their lives; sometimes the acquisition of knowledge fostered a sense of loss - a loss of innocence. Brenda talked about this part of the process after her daughter became very ill and later died:

> …Well, when this happened with Debra, it was like I had crossed over another life that I can never go back to. And that is, it's a kind of knowledge - it's a loss of another kind of innocence that I'll never be the same. And now my life, it's like fall to me. And, you know, there's a movie made called *Damage* with Jeremy Irons in it. There's a line in that movie, "Beware of damaged people because they know they can survive." And that is true. That's how I felt after Debra died. I felt real damaged like - and also, in a way makes you - maybe not hardened - but to where nothing can hurt you like that. I mean - it's a terrible knowledge. I mean, I think you're better off not knowing.

Emotional healing began to take place through the grief process, "letting go," and finding closure that can be found in some therapeutic techniques. Through this healing, though painful, process, Jo found that she could "take care" of herself:

> …I have spent years in therapy. I was very fortunate in 1980, I was under the care of John Bradshaw for several years, and overcame a lot of obstacles from my childhood; like bringing out the "child within me" –the crying Jo. And I would take her in my arms and hug her and tell her that it was going to be OK; that I would take care of her, never leave her or hurt her, and that I love her. And evidently, little by little I got well.

Learning to Make Healthier Decisions

For many of the women, learning to make *any* decision was a first. They simply did not know they had any choices or alternatives to the way they had been living. Therefore, getting sober or going into treatment for chemical dependency were major turning points in the lives of many of the women.

Nora was sober only a few days when the town where she lived began to flood. She and her fellow townspeople worked day and night to "dike" the river. The flooding left her unable to attend any 12-step meetings; soon afterward, she learned her sister had been murdered. She was faced with very difficult decisions in the face of adversity:

> One of the messages that was given to me was that if I took a drink, it wasn't going to bring her back alive; and so I had to ask myself that question every time the pain of that death was so great. And I did, and it wouldn't, and it won't, and so I haven't. But it was a rough way to start.

Helen made her own decision to get help and seek treatment for her addiction - much to the chagrin of her husband:

> And so I had made that decision. And Bob got real mad when I went into treatment…And when I finally made that decision to go into treatment, I had to go through the EAP (the employee assistance program) to secure my job. And I had to go to Austin to meet with the lady. And she wanted me to go in right then. And I told her, "No, I need two weeks to get my shit together. I have a child and

> all that." And so she said, "I can understand that, but they want you to go right now, because they're afraid you'll back out. In that two weeks you'll be healed, you know." And I told her she didn't have to worry about that because I had no doubt at all that I was an alcoholic. There was just no doubt. And so I went into treatment.

Brenda was shown an alternative and choices through her son's counselor after this painful experience:

> And I remember the therapist asked me - this was the turning point in my whole life. The therapist was taking the history of the real horribly abusive situation and he said, "Well, why don't you leave?" And I said, "Well, I don't know how to do it." And he said, "Oh, I think there are a lot of things you could do if you really wanted to." It was sort of the beginning of the second half of my life because I had really not thought of leaving him since I didn't think I could do anything.

The women, at various ages and stages, became open to change, to making plans, and began realizing that nothing or (no-thing) external could "fix them," particularly other people. Sandy shares this realization after she met and married a man in AA:

> And then I fell in love. It was an AA marriage. Although it was a very, very painful thing, it was probably the turning point in my recovery because I had to figure out that no other person was going to fix me.

Helen began to make healthier decisions when she discovered that no one else could "fix her" either:

> for years I had asked him to fix me. The next day, when I would be full of doubt, shame, guilt, and remorse and that fear, you know, I would ask him to fix me. "Something is wrong, we have to fix me. And I wanted somebody else to do it."

The women realized that nothing else could "fix them," thus beginning the transition from changing the external (running, hiding, using alcohol or other drugs to numb the pain) to the laborious process of changing the "inside." All of the participants gathered tools for empowerment along the path to hope; occasionally stumbling while trying to find their way – but finding the way nonetheless.

Learning to Take Action

"Learning to take action" linked the women with outside resources such as therapy and/or 12-step meetings that provided the women with invaluable avenues for identifying current problems and possible solutions.

All but one of the participants attended Al-Anon meetings. Some of the women attended Al-Anon prior to, others after getting sober, in an effort to address the problem "someone else" in their life had with alcohol or other drugs. The participants found tools that seemed to be a vital source of recovery. Instead of learning how to "make someone quit drinking or using drugs" they learned about how to live independently and how to nurture and care for themselves. Some of them may have had to do this in order to get clean and sober. Coming into AA via Al-Anon is commonly referred to as "coming in through the back door." Vicki learned about self-love and self-acceptance from a counselor and through attending CODA (CO-Dependents Anonymous) meetings while she was in jail. Ultimately, and possibly more importantly, what they all found was an end to their internal isolation through beginning or establishing a connection with other

women. After falling down the stairs with her daughter in her arms, Sandy decided to seek information about alcoholism for her husband:

> …And I called Lubbock Counsel on Alcoholism and talked to a counselor. Well, I sat there. I was trying to figure out because see, I was - at that point, I didn't know that I had a problem. The guy I was living with did. So I wanted to find out what to do about his problem. And I got a hold of a very understanding and knowledgeable person. And she said, I "have a problem, too." And she directed me to AA.

Sandy divorced this husband and married a man she met in AA. This AA relationship led her to Al-Anon, which seemed to be the place she learned to break the dysfunctional relationship cycle:

> …So there I was in early recovery, married to a man just like my father… And that was a turning point. And I figured out I could not count on another human being, that I had to finds security and happiness in myself, that I had to understand what self-love meant. I had to start working on that and had to get okay with me. I got very involved in Al-Anon… I think I got a lot of my recovery from Al-Anon. *A lot of my issues are about relationships*. I thought I wasn't okay if I didn't have a man around. It's a long way from there to today I'd rather be alone… I learned a lot of stuff from Al-Anon, because they had greater stability in their lives than I did. And that the addict's way of life is unstable. And they would share with me how they dealt with issues with their children. I learned a whole lot from working in treatment. I learned a lot about affirmation. That it was important to tell yourself (inaudible). And I know that was a real important part of my healing, was getting involved in affirmation.

Lori met her husband in AA. She made her way to Al-Anon shortly thereafter:

> …he never could manage to stay clean; which drove me to Al-Anon and they taught me how to take care of myself - instead of everybody else.

As the lives of the participants began "going to hell in a hand basket," they thought if their "significant others" would just quit drinking or using other drugs, then everything would be okay. Nora exhibited this external mode of problem-solving by locating the problem and the solution outside of herself. This is reflected in her desire for her *husband* to get help for *his* alcoholism. This is how Nora came "in through the backdoor" of AA, through Al-Anon:

> …Anyway, I started going to see the alcoholism counselor - to get Jerry to quit drinking…We'd talk about him. And we'd end up talking about me – inevitably - that's just how it was. So he suggested that I go to Al-Anon. So I started going to Al-Anon. And it wasn't a foreign word because it had been introduced in 1966…

Nora talked about how the bonds of friendship she found in Al-Anon helped her recover:

> …Thelma and I are still friends - I don't go to Grand Forks without seeing Thelma. We laugh about how sick I was. What is a miracle to me is that friendship is still there - and she's not an alcoholic, and I had to cross over to another room, but that bond and friendship is there. And that's recovery.

The participants spent a lifetime thinking they did not "measure up" to some imaginary standard, setting them apart from other people. Through other women, Vicki began to find out she was like everyone else, or that everyone else was like her. She received and internalized this information while she was in jail:

> …There was a girl in there that (had) these pamphlets that had things on self-esteem, self-love - I don't know where they got them, but they had them, and

> they shared them with me. So I started getting that information from those pamphlets, like "Where you're going, where you've come, that you're loved, and everything that's good comes from love. And though it doesn't have the impact now when I say it - at the time it was like rocket science - "You are love and that is where you're going." And then CODA (Co-Dependents Anonymous) meetings - this lady came and brought this CODA meeting once a week…But I got everything I needed there- I got everything I needed to know. I didn't want to get sober until I got everything I needed. That's how I look at it. Some of the information, like the self-love stuff we were getting from this self-esteem class that this woman brought to us once a week. God bless her – God bless her. Because she gave us some other stuff, too - the affirmations mostly I got from her, and the CODA meetings talked about shame - and she gave us a little pamphlet on shame from Hazleton- and I had no idea that shame was my major emotion. And it really was - she made us sit in the middle with everybody and describe it, and everybody had to do it, so it wasn't like another shameful thing and - and they all did it. It surprised me. I thought I was better than everybody else, and that nobody else was interested in getting better or *wanted* to get better - cause they're jail people - and well, I found out I was just like them. And they all talked about their stuff - and they all wanted to get out - and to get better. Nobody there was a hardened criminal - they were just fucked up - some were even illiterate.

Twelve-step meetings are comprised of traditions, procedures and people. Often, the people are as instrumental to an individual's recovery as the procedures they endorse. Women in 12-step meetings were scarce when Nora got sober. She attended AA meetings with 30 men, because, as she says, "the women were still dying in their closets" in 1979. Indeed, she was the only female at the first meeting she attended, and she was the only women in her "home" group for several years. However, in Nora's case, the men's dedication to the common solution of AA helped Nora her see her own truth:

> …Here I was in this room with 30 men and they were talking about God. And meaning it. So at the end of the meeting they asked me if my questions had been answered - and I looked up at them and I started to cry. And I said, "Yeah. My name is Nora, and I'm an alcoholic."

Some of the women lacked the courage to take positive action without the crutch of alcohol or other drugs. The important thing, whether it was before, during or after, getting sober, was that they *did* take action. Learning to take action was an important thread in the tapestry of their lives. Therapy, positive role models, identifying patterns, writing, talking with others on the same path, and prayer were often cited by the participants as providing an avenue for learning how to take positive action. The participants in the current study demonstrated tremendous courage in spite of their fears. Brenda described it like this:

> …It's just so hard. It's like a kid trying to jump off that jumping board into the swimming pool. It just looks so far and scary, but once you do it, it isn't. I've been through several stages in sobriety and I think some of the worst times that - the most difficult times are when you can't go back, but you're scared to go forward. And - but you've got to go forward. You've got to go forward. But it is so scary because you can't see. It's like being blind and walking over a pasture at night but you don't know what's ahead of you. And it takes a lot of courage.

Over time, all of the participants gained faith, helping to dispel and dissipate their fears. They made new friends, and found other individuals like themselves, who had struggled with many of the same problems they had encountered.

Helen described how, over time, different people at various stages of recovery differentially utilize 12-step programs, "Some people, it's their social life; some people it's their spiritual life; and some people, it's their life." In the beginning, 12-step meetings appear to be an important, all-encompassing way to learn about life.

Developing a sense of humor seemed to be a valuable tool in gaining perspective on life. Helen talked about the humor she found in 12-step meetings, and its importance in helping her gain perspective on current and past behaviors:

> …I heard this old speaker say, and I love this, this is so true; He said if a stranger was sitting, a normal person, was sitting in an AA meeting he would think that we were so peculiar because when a new person comes in and they say, "Oh man, you know I've lost my job, my car, my wife," everybody laughs. And a couple of months later, when the man comes in and he says, "You know man, I got my wife back and I've got my car back, and I've got my house back," everybody cries. But I think it's the humor and everything that goes with it. These people being able to sit around and laugh about horrible, horrible things.

Role models were indispensable for the women to learn about how to function in life instead of reacting to situations governed from within due to unresolved issues. Role models, some in recovery others not, played a significant part in helping the participants learn a new way to live. Lori related the following instance in which another person played a significant role in teaching her about life in general, and about herself specifically:

> …This buffet is real expensive - and they are running out of ingredients by the time we get up there - and I'm getting real mad - my head is saying, "You know if you're gonna pay this much for a meal, then they damn well oughtta have what you want." So I'm furious by this time - OK? Well, this man in front of me, he gets up there and they ask him what he wants. He tells them, and they tell him they're out of that. So he says, "OK, whatever you have, then." Just like that. And I thought, "Oh." I had to ask him, "How did you do that?" He said, "What?" "Aren't you a little upset that they didn't have what you wanted?" He said, "No, I'm still gonna get to eat and I'm not gonna be hungry." I mean this was a concept that was totally foreign to me. Nothing had changed "out there" in the world, but my perspective had changed completely and totally. And that man will probably never know what a lasting and revolutionary impression that he

> made in my life. That may sound really stupid and really simple, but that man was a living example and he showed me how to act - instead of react.

As new ways to cope were integrated, healing transformations occurred and the process of becoming whole was set in motion. These healing transformations most often occurred over a long period of time, but occasionally were experienced and described as miracles, spiritual experiences, spiritual awakenings, or instantaneous healing. Also, these phases overlapped, cycling over and over as old ideas and behaviors become self-defeating or obsolete and as new ideas and knowledge became integrated into the women's lives. The women began to learn how to function in life. The foundation had been laid for them to begin or continue exploring the internal "stuff" from which much of their dysfunction had arisen.

Theme V: The Process of Becoming Whole

The inner turmoil and conflict these women had experienced as children, compounded with the guilt and shame associated with women and addiction had isolated the women further from themselves, as well as from other people. (i.e., Brenda's hiding her real "self" behind her bellybutton, Lori's walls that were 10 feet tall and 3 feet thick). The drugs and the alcohol had been a major part of these women's lives. They needed something with which to replace these self-destructive behaviors, in addition to finding a way to heal the trauma and the pain in order to become whole. A large part of the recovery process for the participants was "connecting" with other women who had traveled similar paths through the treacherous addiction process and, yet, had become

transformed. These other women, members of the tribe, were an essential component of the recovery process. "Members of the tribe" provided a connection to other women with similar troubles, and therefore the members of the tribe worked by giving the participants an unparalleled sense of belonging and level of identification. Developing friendships with other recovering women was indispensable, and the support systems were necessary.

"The process of becoming whole" contains inspirational and amazing stories told by the women who participated in the study. They were moments when the women knew that they had experienced nothing short of a miracle. They were consciously aware that something had been given that was desperately needed; and others were aware that something had been taken, that desperately needed taking (See Figure 5).

Members of the Tribe

Although 12-step meetings provided the participants with tools for learning how not to use alcohol and other drugs, it seems that other women taught them how to recover their souls. "Members of the tribe" were instrumental in providing the women in the current study with an alternative frame of reference for identifying feelings and past behaviors with a level of understanding that they probably could not have received anywhere else. The women talked about the relief that came from finding that other women, whom they considered "ladies," had done many of the same "shameful" things that they themselves had done. This revelation gave the participants hope.

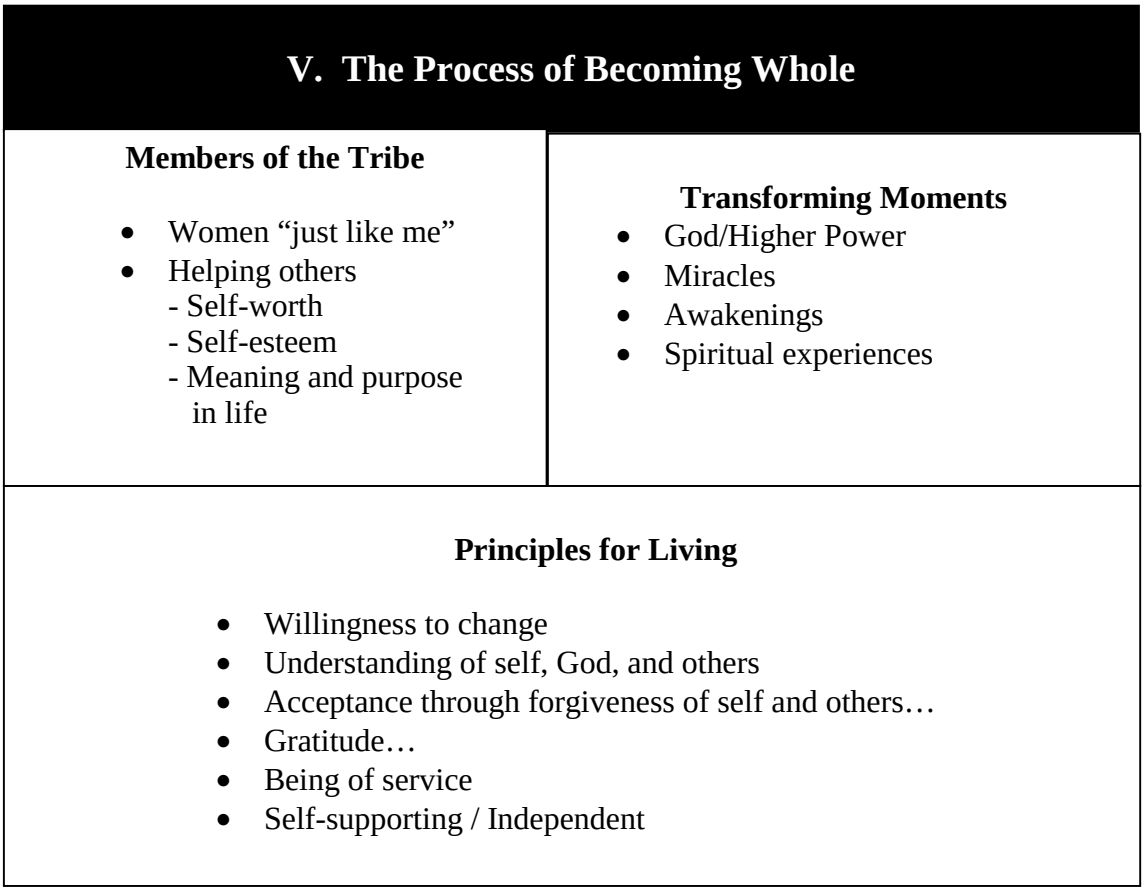

Figure 5: Theme V: The Process of Becoming Whole

The participants in the current study had heard the popular phrase "they were not 'bad' people trying to get good, but rather they were 'sick' individuals attempting to get well." The "members of the tribe" helped the women to internalize this concept by accepting them just as they were, thus establishing a connection with other women with whom they shared a common path that promoted the healing process. In return, their job was to "be there" to support new women as they came to find "members of the tribe." Eventually, the women could forgive and accept themselves. This circle, one

woman helping another, gave the participants' tremendous satisfaction, self-esteem, confidence, and meaning and purpose in life. If you remember, Nora was the only woman in her AA group for several years. She grew tired of being the only woman. Yet, she learned that she needed to be there to help the next woman, which in turn, also helped her:

> …now up there that "use guys" is a phraseology that has to do with a geographical thing like we say y'all down here, they say "use guys" up there and he said "use guys" and I lost it. I did. I lost it in a meeting at a year and a half (sober). I said, "I am so tired of being here with only you guys and you say use guys and I am not a guy! I'm a girl." And I was a bit indignant –just to say the least. He looked at me like weird and he said you're one of the guys. You're one of us. It kinda took some of the power out of it. But I had made up my mind that I wasn't going to go to AA. So come Friday, and I can't believe I bought this, but I bought it hook, line, and sinker, anchor and the whole boat—he (Robert B.) said, "If you leave who's going to be there for the next woman who comes along?" And I thought about that, and I wasn't saying those two nasty words so much anymore, and I said, "I don't know, I'll think about it." And I didn't leave. And it was within the next couple months that a woman came along. And she celebrated 20 years of sobriety on the 8th of March. And I was her 1st sponsor.

Helen talks about the first time she experienced truly "connecting" with another woman in recovery by connecting through the same behaviors she allowed to keep her separate for so long:

> …And I'll never forget, I had about four months sober and Lauren - Chatty Cathy Lauren - blonde-headed, talks real loud. Anyway, Lauren'd gone through treatment right after I did and she came over here and she'd just gotten out of treatment and we were talking, and sharing about things; she's a counselor today. We were talking about the things we did and Lynn told me she had been sexually involved when she was real fucked up, you know, with a woman. And I was like, "No shit? (laughter) So did I. My God that's awful," (more laughter). And so it was that kind of experience that allowed me to see a crack of light.

The addiction process battered the women from the inside out, with feelings of shame and guilt, especially when children are involved. Sandy found that much of her self-esteem revolved around her issues with her children:

> …And I think women have specific issues with children that men don't have. Because I think for a lot of women a lot of our self-esteem is wrapped up in being mothers. And then as addicts we don't see ourselves as good mothers. And so that place where we get our self-esteem is also where we get the lower self-esteem. And I think that there's just a lot more that needs to be done in terms of working with women on learning how to - communication skills for the short run. Learning not to repeat those patterns…

The women supported the recovery process by nurturing one another, especially in times of crisis. Not only did the "members of the tribe" offer emotional support through the sharing of painful experiences, they also, in order to help the participants to "move on" past the pain, would not allow each other to indulge in self-pity. Helen described how other women kept her from the self-pity that often can be treacherous for the recovery process:

> …It was real hard …having feelings of anger, and not medicating them. Because that is what I always did with them. I learned to deal with that really hard stuff… I did by talking to other people in the program and by talking to God. I would call Nikki sometimes and she was always mean to me, which always helped me get through it. I called her one time; it was when I was taking two college classes through the phone company, algebra and beginning geometry, and it was kicking my ass. I made an "A" in both of them - but it kicked my ass. I had no life. So I called Nikki up to whine. I called her and told her, "I've had it - this is it." She listened to me and then she said, "Waa, waa, waa." And I said, "Nikki," and she said, "let me tell you something, Helen." She said, "You need to get on your knees and thank God for allowing you the opportunity to go to fucking school."

> And I thought, "You bitch." And that was one of the miracles that got performed in my life.

In essence, the women discovered they each were not "hopelessly bad" and were able to share that revelation with each new woman as she came to her first 12-step meeting:

> …the newcomers realize that they're not so bad and they're not so unique. And that people have done a whole lot worse than they have. I think that's how we all feel when we first get here; that we're just so bad. I mean, it was such a revelation, it was such a load off of my spirit when I found out I was sick. Because I really thought I was just hopelessly bad.

Lori received acceptance from other women who had been through the addiction and recovery process. She talked about the "Members of the Tribe" and their role in the process that transformed her life. She, in turn, gained insight and awareness by helping other women:

> …I started working with other women as they came into the program - and I started feeling like I was a worthwhile human being that could contribute something to society. I don't believe that you have to go through a 12-step program or treatment to find recovery - but the validation I got from hearing other women tell their stories - they had done the same things - I felt such relief and such freedom - I found out I wasn't hopelessly bad, I was sick and needed to get better. I found acceptance and love with women who wanted the same thing I did: not to ever have to go back to living the hell we were living. As long as I remember where I came from, and as long as I share that with other people who are suffering - that keeps me grateful, and as long as I am of service to God and to others, and as long as I maintain a relationship with that God that I understand - and try not to intentionally hurt another living being - then my life stays incredibly good. I don't know who said them but there's a couple of sayings that I like; one of them is, "We're as sick as our secrets, and our secrets grow in the

> dark, but when the light is cast upon them, they no longer hold their power over us…"

The participants came to 12-step meetings seeking relief; what they found was much greater. The women learned about what it meant to be "human" by finding a connection and sense of belonging with "members of the tribe." They no longer needed the alcohol and drugs for survival. The "members of the tribe" were instrumental in helping the participants develop self-worth and self-esteem. By utilizing the 'bare bones" of the principles they brought with them, the women in the current study were able to fully develop principles for living. These principles were willingness, understanding, acceptance, gratitude, faith, and spirituality.

Principles For Living

The women were encouraged by their new-found usefulness, and continued, through working with others, to more fully develop the positive characteristics that had helped them survive for so long…principles for living.

The women really had the principles for living all along. During the recovery process, these "defects of character" (to borrow an AA phrase) were transformed into assets. Jo was willing to go to great lengths to maintain her recovery:

> …I stayed in Comfort, and went to that little women's group and the brown bag every day; for the first two years I went to two and three meetings a day. That was the only way that got me through there.

Helen was willing to do practically anything anyone in recovery asked her to do her first year of sobriety:

> …And you know that first year I was so afraid of relaxing that I would have done practically anything anybody told me to do… go to 90 meetings in 90 days, I was willing to do that. And every once in a while I would make two meetings a day and not go to a meeting the next day. But I made those 90 meetings in the 90 days. And they told me to get a sponsor and I was willing to do all of that - it was out of desperation - because I didn't want to relapse.

Nora found gratitude for her recovery and willingness to go the extra mile from the place she least expected, from a place she went to share her faith and gratitude, in prison. Gratitude, faith, and willingness, as well as spiritual development that comes from working with other women, was evidenced in the following story:

> …So I drove up to Gatesville to the women's penitentiary. My very first trip up there, I heard a woman tell my story, and she's doing my time. She was there for attempted murder. She neglected her kids. She beat on her kids, and she didn't think she was that bad. She got sent to prison, and I didn't. So I went once a month, and I did that for quite a few years; that's what I call "doing my time." I didn't do it to do my time, I did it because that's how I did my time. I did it because I wanted to, and I realized through that woman, and through Walter, that I was no different than anybody else; I tried to kill my first husband, and I hadn't talked about that until I was 7 years sober, because people I knew didn't do that kind of thing. Walter would be coming in off the road from a week, two weeks, three weeks, and it would be my day to go to the penitentiary; He'd just say, "Bye darling, have a good day, I'll see you when you get home." And that vow that I made to work the program - it didn't make any difference - it was true - he didn't try to make me stay home and be the wife or meet his needs or be with him. He knew I needed to go and that was my commitment and that was what needed to be done. And that's pretty incredible.

Like self-forgiveness, forgiveness of others seems to be a key in the process of becoming whole. Brenda talked about the "miracle" she got regarding her feelings toward her own mother. Brenda sought help through therapy for many years to resolve sexual abuse issues that had involved her mother, with only some measure of success. She told the following account of how she finally was able to overcome those tortuous feelings that had involved her mother:

> …But I had a miracle happen with my feelings toward my mother. And I really don't know what brought it about. But it was just all of a sudden it was just like, what difference does it make what happened all those years ago? …I think it's a miracle. I really do. I think that there's one thing that therapy cannot breach and that there's certain things that can only be healed spiritually, that they can't be healed through therapy. And I do think there's a point where you just have to get out of it and live life. And if you're lucky, you get a miracle, I guess. You know, it's nothing that I earned or did anything to receive…well, I think out of a dream, maybe. And I woke up and it was just like none of that mattered any more. And - but I had suspected for a long time that Mother probably had been sexually abused because she had so much knowledge of her parents' sexual life. And I thought, my God, that was like - she was born in 1910. And I don't think there were kids back then that knew what their parents sex life was…And so - and I knew Mother had been sexually abused as child…

Like Brenda, Jo also sought therapy for her "childhood issues" involving severe physical, mental, emotional, psychological and sexual abuse. The result was forgiveness. This is her account:

> …I overcame a lot of obstacles from my childhood; like bringing out the "child within me" –the crying Jo. And I would take her in my arms and hug her and tell her that it was going to be OK; that I would take care of her, never leave her or hurt her, and that I love her. And evidently, little by little I got well. It was very painful, I would be in the fetal position for a lot of the time. Some bitterness crops up about the past; well, those were just the cards that were dealt to me.

> That's gone. I went to my parents' grave, and I had to say, "I forgive you, and you did the very best with what you had to work with." I wrote them a letter and I read it out loud. After that, I never looked back on that.

Lori talked about forgiveness, as well as other components (i.e., learning how not to be a victim, to identify destructive behavior patterns in order to change them, and letting go of defense mechanisms) that were important to her recovery process:

> …I learned how to not be a victim - to write about everything that happened in my life so I could look at it, to see what my patterns were, so I didn't have to keep doing them, and to tell one other person everything I had done, and to forgive and ask forgiveness. And I had to make amends to all those people I had harmed - and I found out the person I had harmed the most was me. And then I had to look at my character defects - those things in my character that keep me sick - and then I had to be willing to let go of them. That was probably the hardest thing - because that meant letting go of the façade and the wall - the things that I had needed to survive. But I had found a God that would take care of me and I didn't need those walls anymore and so, I learned that if I wanted to get better, then I had to do these things whether I understood them or not. So I did because using was scarier to me than the alternative of not knowing what would happen if I let go of these protective mechanisms. And so I did. And I got better. Today, I know it was the process that freed me up to live my life instead of reacting to it.

Independence and becoming self-supporting were extremely important components of the recovery process. The participants had been dependent on undependable people most of their lives. For Sandy, self-forgiveness was vitally important:

> …Forgiving myself for the things that I had done and thinking that I could be a productive member of society because I had … dancer and porno movies and all that. So dealing with those issues were the big issues for me. And they have been a lot of the big issues…But were not resolved in treatment...

Sandy also thought that women have some very specific issues, like developing independence, that needed special consideration:

> …I think women have some specific issues. Issues on learning how to be self-supporting in every sense of the word without a man. To learn how to rely on themselves and on their power. But men don't face that kind of issues. The traditional programs aren't really geared toward learning how to disentangle yourself from your dependency on other people.

The "members of the tribe" provided the women an avenue for healing through support, through providing a safe environment and by sharing their own personal experience stories with the participants. The women found a connection and acceptance, and, in return, could offer their own experience to new women who needed their help. The process of recovery initiated through others was instrumental in helping the women in the current study develop principles for living with themselves and others. For the women in the current study, in addition to finding "members of the tribe" and "finding themselves," they also found that sometimes….they were transformed.

Transforming Moments

Transforming moments were one form of epiphany experiences in the participants' lives. Transforming moments were called miracles, awakenings, or spiritual experiences attributed to God. "Miracles" in transforming moments are those accounts that the participants contribute or ascribe to Divine Intervention. Nora's last

attempt to commit suicide was foiled; she decided, "no one dies without God's permission."

> …So I decided to kill myself. So when Jerry went to bed I went to start the car and put the garage door down and proceeded to go to sleep. Jerry usually slept all night because he passed out, but for some reason (well, God) he didn't sleep all night, and he woke up and heard the car running and rescued me one more time. And of course my response to that was just to be pissed at him for rescuing me because I wanted to die. Or so I thought. And I probably did, because I didn't like what was it was feeling like on the *inside*. And that was the last big suicide attempt. Some of those were cries for help, and some of them were just desperate attempts to check out - to be done with the pain. I truly believe that no one dies without God's permission; and it just wasn't my time, and hasn't been my time up to this moment. I don't know about the rest of the day because it's not over. So far, it just hasn't been time.

God was not ready for Nora to die. Indeed, she avoided death a second time, by what she called a miracle, when her house filled with natural gas from a malfunctioning furnace:

> …Walter was out on the road, and it was about 5:00 a.m. Saturday morning, and he was in Connecticut. He got this funny feeling that something wasn't right, so he called home. Our furnace had quit working a few days before this. They had spent 3 days trying to get it fixed. They finally got it fixed Friday afternoon, and this was January so it was chilly. I went to sleep, and the furnace was right beside our bed….The phone rang. The weird thing about that was, the phone that rang was the one by the bed, and the ringer had been broken on that phone for over a year. And it rang. And I couldn't believe it - and I came to, and I didn't want to come to. I was off in the space that was so serene and there was a light and it was so peaceful and I didn't want to respond to that (phone) but I did. It was Walter. …He asked me if I was alright, and I said, "No, but I'm ok…I couldn't make sense of anything he was talking about... He kept asking me, "Are you sure you're alright?" I said, "I feel weird and have a terrible headache and you know, it stinks in here." He said, "You need to call somebody"… Meanwhile, he is out in Connecticut and knows something is wrong. He calls his daughter in Round Rock, who had gotten Rhonda's (the neighbor) telephone

number *one week* before. He calls Rhonda and tells her to come over and get me…

Spiritual experiences facilitated self-acceptance. The participants received messages that they were loved. Sometimes these messages came from members of the tribe; sometimes they came from beyond. First with Lori:

> …I heard this voice - I had no doubt it was God - no doubt - it wasn't man or woman's voice, but it was pure calm, and serenity and love and it said, "If you had been the only one, I would have come. I love you just like you are. You don't have to change for me to love you. You are perfect just like you are." I felt such acceptance and such love like I had never known. That changed my life forever. And I went to bed. I got up the next day, and I haven't found it necessary to drink or use drugs ever since.

Then with Vicki, who had several profound experiences:

> …Because in my experience with God, God is not uncomfortable. I don't know – V – I've just never really paid much attention to people who say they see things - or clairvoyance or anything - I've never known anyone that I thought was credible - but V *is* like that. She sees and hears things that I can't. But, you know, now she's comfortable…There was this one night though, now she saw an angel or something over me, honestly…But right after she saw this angel, that's the week I had …just this peace. Like that peace that I had in jail. That everything is the way it's supposed to be, and you know it. And anyway, this angel he was naked – and parallel over me - and he reached into my solar plexus, and she had the idea that he took something out, but before he did it, he realized that she was aware of him - and he kind of looked at her - she said he didn't, like – *hurry* - but he did his task and left. And she had the idea that I was aware of him - but I'm not ready for that yet - it's just too much for me (laugh) - but this may sound crazy but the way that I know her, I believe her. I remember - I don't know if it was an actual voice, but, - I love you, Vicki. That's what I heard. I would get down onto my knees and pray the first year I was sober. You know, I wanted so bad …I had done my affirmations before that, and, anyway I had done those, and I sat down and I said "I love you, God" and he said, "I love you, Vicki," and I said, "Really?" And it was like, right in here - inside in my

> midsection. If it came from anywhere, it wasn't out in the room - it was right in my mid-section. And immediately, Fear said, "That's the devil trying to fuck with you!" And I knew to just push that thought away. Just take it in. It was a nice feeling - a nice everything - "I love you, Vicki."

Vicki also struggled with issues involving re-uniting with her daughter:

> …I heard God on an airplane. It was booming - it was loud. I was ten months sober. And I was debating in my head, "Do I go to Hawaii - (where her daughter and parents were) or do I stay in Phoenix where my recovery is?" I was so unhappy; and it was just really a struggle. I was going to visit her, and when we got off the ground and I could see all of Phoenix and everything, and these big, old, red mountains, and this big voice (this is so the cliché - but I swear this is what I heard) I will never forget, said: "YOU LIVE IN THE DESERT!" And it scared me. And I remember looking around and no one else seemed to hear him, and I remember thinking, "OK - I think I'll leave this one alone." It was so funny to me - You live in the desert.

Vicki got sober while she was in jail. She shared that for the first time in her life, she felt loved and accepted…in a room all alone:

> …I thought they were taking me to court to bring up new charges - it was the middle of the night and I was scared - I had only been there a couple of days - I thought, "This is when they are going to give me the attempted murder charge." And so I sat in that little room by myself, and for the first time that I ever really remember in my life, I looked down at my hands and I looked down at my arms - and I felt OK - not just ok - but like I loved myself for the first time - and this feeling sort of washed over me - and the state I was in I don't think it came from me - I just don't see how it could - I honestly just felt all this love - and I've often wondered if I got in that bad of shape again would he do it for me again?

The previous stories are only a handful of what the women shared. Their narratives contained many more remarkable accounts, and the task of including only a few was quite difficult. More than trench hole experiences, these events provided the

women with unshakeable faith, a sense of peace, and an avenue for developing spirituality. These transforming moments helped the women develop principles for living as they continued on their journey to becoming whole.

SUMMARY

The data suggest that addiction arises from cycles of abuse. These cycles of abuse produced an internal state of "disconnectedness" among the participants, evidenced by self-destructive behavior. The physical, spiritual, mental and emotional pain of reality became too much to bear as the women started using alcohol or other drugs to help them quiet and numb the internal insanity while helping them maintain an façade of "wholeness". The women were well-advanced into the addiction process when all previous coping mechanisms began to fail.

Unlike Humpty Dumpty, the women found a process for becoming whole. They found a new way to live. Recovery may be initiated by the desire to cease using alcohol or other drugs, but is facilitated by the maintenance of internal solidarity of peace and contentment.

CHAPTER 5: CONSTRUCTION AND CONTEXTUALIZATION

Introduction

The purpose of the current study was to document common themes of the addiction and recovery process among women recovering within the framework of a 12-step fellowship related to alcoholism and other drug abuse problems. Within this context, the research question was, "How do women who have relied on the framework of 12-step programs personally experience the addiction and the recovery process?"

As mentioned in Chapter 1, in studies of concepts that lack universal definition, such as the study of the addiction and recovery process, where there is difficulty in distinguishing one definition or process from another, the interpretive interactionistic research approach is appropriate (Chiu, 1996). In the current study, unique and separate concepts emerged from the data that define and relate each theme to the addiction and recovery process.

Interpretive interactionism is an exploratory method designed to explain the world of experience and to help clarify its important phenomena (Denzin, 1989). Personal experiences, when viewed from within cultural and social contexts, often present a different interpretation of traditionally defined problems. The personal experiences of the participants in this study clearly linked abuse and violence, especially in the absence of a caring support system, with both conscious and unconscious

avoidance and escape strategies that included chemical usage as one type of survival mechanism utilized to avoid, escape, and/or tolerate physical and emotional pain. Abusive conditions create hostile environments that were found to be a major factor in the development of internal fragmentation and dissociation evidenced by the participants' development of specific mental conditions and self-destructive behaviors, including alcohol and other drug abuse.

As prior survival tactics became increasingly self-destructive and reached critical mass, the participants' lives became inundated with cumulative "jolts of reality", forcing the women to seek alternate solutions that launched them on a serendipitous (when timing meets opportunity) journey of healing. This journey incorporated not only abstinence from alcohol and other drugs, but also included synergistic bonds, especially connections established with other women that promoted re-connecting the spirit and thus facilitating recovery of the "self." Commonalities or themes recognized in the interviews for the addiction and recovery processes were discussed in Chapter 4. This chapter relates the findings to previous studies and contextualizes themes and sub-themes by grounding the accounts of problematic events (i.e., such as those experiences associated with the addiction and recovery process) in the relational world to those of the participants' (Denzin, 1989). Contextualization, or conclusions drawn from these interpretations, and future recommendations are also discussed in this chapter.

Construction

"Construction" attempts to interpret the event or process by classifying, ordering, and reassembling the phenomena back into a coherent whole (Denzin, 1989) and by showing how lived experience alters and shapes the phenomenon in question. The current study identified five major themes related to the addiction and recovery process. Theme I, "caught in vicious cycles," represented several cycles that perpetuated and exacerbated one another.

THEME I: VICIOUS CYCLES

Vicious cycles included the sub-themes of "hurting the ones you love," "out of touch" and "keeping up appearances." In the current study, "hurting the ones you love" categorized abuse that was perpetuated from generation to generation. This included sexual, physical, verbal, emotional, and/or psychological abuse. All of the participants were abused and victimized over the course of their lives, and they in turn repeated abusive behaviors with their own children. Estimates of physical and sexual abuse among chemically dependent women have been reported as high as 75% (Root, 1989). Streicher-Bremer (2000) also found that women who were addicted to heroin were often victims of childhood sexual abuse. Furthermore, these women reported that they were forbidden to disclose the behaviors of their perpetrators through having to "keep secrets." This was called "keeping up appearances" in the current study and served to

hide the abuse, violence and the parental illnesses or conditions that also contributed to the hostile environment that surrounded these women.

The women in the current study were victimized as children, and had all by definition, been addicted to alcohol and/or other drugs at some point in their lives. The participants frequently suffered from other disorders, such as depression and anxiety, and had family histories of abuse and rigidity, supporting findings that associate the combination of abuse, domestic violence, or other trauma with the co-morbid development of chemical dependency, depression, PTSD, or other mental disorders.

Many of the participants in the current study had one or both parent(s) who suffered from depression or mental illness and/or who were addicted to alcohol or other drugs. Both the participants and their parents had developed one or more of these disorders characterized as being "out of touch." Being "out of touch" referred initially to the participants' parents, and later to the women themselves, who suffered from mental illness in addition to their problems with alcohol or other drug abuse. Parents who are depressed or have some other mental condition may not cope with their problems appropriately and are often unavailable for their children (Hillis, Anda, & Marchbanks, 2001). The parental alcoholism and/or other drug use further exacerbated and escalated the violence experienced by the participants.

Gil-Rivas, Fiorentine, and Anglin (1996) found that physical or sexual abuse often contributed to the development of other psychological disorders, such as PTSD, depression, anxiety, anger, self-destructiveness, and suicidal behavior. Radomsky

(1995) illustrated the connection between physical and mental health concerns experienced by women during their adult years (such as chronic pain, depression, anxiety, and undiagnosed physical ailments) and family histories of abuse or rigidity or both. Feiring, Taska, and Lewis (1998) found a strong association between current psychological distress, depression, self-esteem, PTSD, and a history of sexual abuse regardless of age or gender. A large body of evidence supports the assumption that traumatic experiences are associated with, and interpreted as the underlying root cause of this related set of disorders expressed in various forms (addiction, alcoholism, PTSD, depression, anxiety, etc). Hillis et al. (2001) examined adverse childhood experiences defined as physical, verbal, and sexual abuse, witnessing of intimate partner violence, and living with adult family members who are substance abusers, mentally ill or suicidal, or who have been imprisoned. They found exposure to these adverse childhood experiences significantly increased the risks associated with major causes of death and disability in adults, including alcoholism, drug abuse, depression, suicide, and smoking, among others.

The participants' experiences in the current study mirror the findings reported by Coid et al. (2001), who found that unwanted sexual intercourse was associated with subsequent experiences of domestic violence and rape in adulthood; and that severe beatings by parents or care-givers were also associated with subsequent experiences of domestic violence, rape and other trauma. Domestic violence is cited as one of the top-reported leading causes for becoming homeless, and not surprisingly, women head

almost all homeless families, in which becoming homeless contributes to the downward spiral of addiction (National Women's Law Center, FOCUS/University of Pennsylvania, and The Lewin Group, 2000). Domestic violence was a common occurrence in many of the participants' childhood residences. The women often repeated this pattern by marrying an abusive partner, bringing domestic violence into their own homes as adults, thereby exposing their children to, and perpetuating the same vicious cycles.

Lewis (1992) found that long-term abuse, whether physical or psychological, can cause changes in brain structure and function. Chemical dependency is exacerbated by these structural and functional changes that occur in the developing brain as an adaptive response to exposure to a brutal environment. Fishbein (1998) reports that violence and abusive experiences may cause structural changes and neurological dysfunction to occur in the developing brain. Chemical dependency contains a genetic component passed on by the parent, not as a *cause* of addiction per se, but as a genetic *predisposition* (Fishbein, 1998). Therefore, being "out of touch," as exhibited by the participants in the current study, as well as at least one of their parents, may be linked with genetic, neurobiological, and environmental causes. Although this study could not address these genetic and neurobiological issues directly, it lends credibility to support further investigation in this area.

THEME II: I HAD TO ENDURE WHAT I HAD…

Theme II, "I Had to Endure What I Had…" represents the suffering and trauma experienced by the women in the current study. The sub-themes included: "I had…to

adapt," "I had…no idea what it felt like to be OK," and "I had…little if any, hope for change." Alcohol or other drug use may serve to "balance out" an unbalanced system in an attempt to restore some semblance of internal homeostasis. Several studies support the association of chemical dependency as a coping strategy utilized for dealing with traumatic experiences (Salmon et al., 1999; Kearney, 1998; Lowery, 1998; Goulding & Schwartz, 1995; Horney, 1992) like those experienced by the women in the current study. The participants utilized alcohol and other drugs to adapt to an environment fraught with abusive experiences.

Could utilizing alcohol and other drugs to adapt be likened or compared with other adaptive responses? For example, the chronic stress response that once promoted survival has been associated with the subsequent development of heart disease, high blood pressure, and a host of other leading causes of death in the US (Seaward, 1997). Just as this "general adaptive response" to stress described by Seyle (1976) has become a detrimental variation of the "fight or flight" response that was originally a basic survival instinct, similarly, it stands to reason that the individual adaptations exhibited by the women in the current study *could* also be a variant of an instinctual survival mechanism. A basic survival mechanism that was possibly developed as an adaptation in response to traumatic experiences that produce a given set of adaptive responses (depression, dissociation) on the psyche specific to a given set of abusive circumstances.

Kearney (1998) utilized 10 research reports from diverse contexts and applied grounded theory and constant comparison method for analysis. The basic problem of

addiction was found to be self-destructive nurturing. This concept was defined as drug use to ease discomfort in order to take care of oneself. "I had... to adapt" in the current study meant, when they were old enough, physically "getting away" from their perpetrators. "I had…to adapt" also refers to mental escape, denial of the circumstances, or changing the way the participants' felt or perceived reality by altering states of consciousness through dissociation, repression, and later, through the use of alcohol or other drugs. Rasanen (1998), who has written about natural and human disasters, states that if a human being is in a situation where s/he is totally powerless and has no possibilities for resistance and where there is no escape, then s/he can only change the state of consciousness. Often, these ways of adapting, or altering states of consciousness, utilized by the participants, consciously or not, were demonstrated through mental breakdowns, attempted suicide, or emotional dissociation. Often they pretended that abuse "didn't exist" for so long they believed it themselves. Several women had no recollection of physical or sexual abuse – but did retain a very definite "sense" that something was "not quite right." Memories of traumatic experiences began to emerge for many of the women after seeking psychological therapy or after having been clean and sober for a number of years.

Baer et al. (1997) found that survivors of oppressive conditions had very low self-esteem and a tendency to accept prevailing negative social stereotypes about their ethnic group, social class, gender, or sexual orientation. Resulting depression and anger at others for having been found so worthless, was cited as their principle reason for

addiction. The impact of suffering from social mistreatment and, at some level, believing one doesn't deserve better (Baer et al., 1997) is characteristic of the experiences with powerlessness and the lack of resources to effect change. Continued oppression further reduces the opportunities and life options available to victimized individuals similar to the participants in the current study.

An extensive body of literature has been written about the utilization of alcohol as a "coping" mechanism for dealing with victimization issues. Emotion-based theories of drinking behavior are supported by the current study. All of the participants utilized alcohol or other drugs to escape, avoid, or regulate trauma-related emotion. Although drinking to cope was called "adapting" in this study, other studies have used "coping" as a term to measure a similar construct. Holahan, Moos, Holahan, Cronkite, and Randall (2001) found that drinking to cope was associated with more alcohol consumption and drinking problems over a ten year period compared to baseline measures. They also found a link between anxiety and depressive symptoms at baseline and drinking outcomes. All of the participants in the current study, however, were also addicted to drugs other than alcohol, suggesting applicability and expansion of Holahan et al. (2001) findings to include addiction to other drugs, in addition to alcohol.

The formation of self-image development becomes very skewed for an individual who has been exposed repeatedly to traumatic events as expressed by the participants in the current study. "I had…no idea was it felt like to be OK" refers to the omnipresent feelings of guilt, shame, inadequacy, and the underserved right to be human. These

feelings of inadequacy are common among women who have been victimized (Hanna et al., 2000). Oppression through deprivation is described as an act that deprives another or others of an object, role, experience, or set of living conditions that are desirable and conducive to physical or psychological well-being. It includes the deprivation of loved ones, respect, or dignity. Neglect is another form of oppression in which a person is deprived of love, care, support, or vital services as well as basic material needs such as food, shelter, and clothing. One can also be deprived of one's children, parents, friends, freedom, or even one's childhood (Hanna et al., 2000). The women in the current study were raped, beaten, many of them robbed of their childhood, and deprived of basic human rights, especially freedom.

Oppressive illness is a term used to refer to chronic traumatic effects of experiencing racism, classism, and related oppression over long periods of time combined with the negative emotional effects of intense self-disparagement associated with being the enduring target of social bigotry (Baer et al., 1997). The experiences related by the women in the current study included oppressive conditions rife with neglect, abuse, and deprivation, constituting "traumatic effects of oppression over long periods of time" that produced negative emotional effects, like feelings of guilt, shame, and inadequacy, compounded by guilt over the very behaviors over which they depended for survival, and, over which they had no control.

THEME III. GOING TO HELL IN A HAND BASKET

Theme III, "going to hell in a hand basket," represents the individual whose life is falling apart. Many of the participants experienced "jolts of reality," like ending up in jail or suffering from overwhelming fear and/or attacks of panic, followed by the "dark night of the soul," as defined in this study. "Jolts of reality" were negative events that began to occur more and more frequently in the participants' lives as a direct or indirect consequence of their drug use. Personality changes, often referred to as Jekyll and Hyde by the participants, began to occur unpredictably as result of alcohol or other drug use. The salient solutions these women had found, particularly alcohol or other drug use, subsequently became a greater problem for the participants than the ones they were trying to avoid. Horney (1992) discusses this phenomenon from a Jungian point of view as complementary personalities; however, the participants drove these personalities to the extreme by their continued alcohol and other drug use. They found themselves in more emotional pain than ever before when their drug use created more problems than it solved. Often, their drug use had become so automated that the possibility that chemical dependency might be contributing to their misery was never even a thought.

As altered states of consciousness became more difficult to sustain as the participants grew older, the women in the current study began using alcohol and/or other drugs to survive life as they knew it. Goulding and Schwartz (1995) and Northrup (1994) defined women's use of substances in direct relation to survival, as a response to living in a culture that is sick. Other studies acknowledge the physiological

underpinnings that support this hypothesis. Drug receptor sites located in the MFB have been designated the "like-want" pathway. These regulatory sites control dopamine, seratonin, and norepinephrine (Sullivan & Hagen, 2002). This pathway controls not only the regulation of drugs, but also the drive for sex and hunger (Fishbein, 1998). Weil (1971) purports that the desire to alter consciousness is an "innate need," analogous to hunger or the sexual drive, and that drug use is only *one* of many ways of satisfying this drive. Since the drive for sex is necessary for survival of the species, and the drive for hunger is necessary for survival of the individual, is the drive to alter consciousness necessary for survival of an unrecognized need, perhaps survival of the "spirit"? However, the problem with using drugs to alter states of consciousness on a regular basis is that, eventually, they (the drugs) fail us over time and serve to limit freedom, rather than to liberate (Weil, 1971). The participants' experiences with "jolts of reality" that served to limit their freedom, followed by the "dark night of the soul" in which the drugs failed them utterly, bears witness to this phenomenon.

Kearney's (1998) theory of addiction and recovery included a "painful shift in awareness" when substance use became a problem. The initial shift was gradual in nature, but began to resemble the "jolts of reality" in the current study as these crises began to occur more frequently. Crises mentioned in both Kearney's (1998) and the current study included problems with children, difficulty with and/or increasing public interference in personal affairs, and emotional pain. When the participants' solutions (running, hiding, ignoring, denying, or using drugs) became ineffective and created

problems that were more severe than the ones they were intended to solve, the women in the current study were faced with the options of either carrying on the best they could to the bitter end, or finding a new way to live. All of the participants' past experiences led to the culminating event defined in this study as the "dark night of the soul." The "dark night of the soul" reflects the overwhelming psychological distress welling up within the participants as they faced the reality that drugs could no longer keep the pain from crashing down upon them. They began to realize they could no longer function with or without drugs.

THEME IV. LEARNING HOW TO LIVE

Most of the participants grew up surrounded by violence and substance abuse. Therefore, they learned to cope with their problems based on the dynamics of a dysfunctional model or system. Theme IV, "learning how to live" represents the struggles and difficulties faced by the participants in the current study as they learned alternative coping strategies without utilizing alcohol or other drugs. They had to *learn* how to grow through pain without using drugs. "Learning how to live" also involved "learning to make healthier decisions" as well as "learning to take action," as well as "learning how to grow through pain." The participants learned how to grow through pain and into wellness by finding closure and emotional healing through the recovery process.

The women learned to make healthier decisions. They demonstrated these healthier decisions in the outcome behaviors of seeking treatment, getting sober, and by

becoming open to change. The women in the current study gained a variety of beneficial coping skills from their connection with other members recovering within the framework of the 12-step programs. The connection with other AA and NA members provided the women with a source of social support with individuals with whom they shared a common goal: Abstinence for survival. The abstinence philosophy seemed to come from AA and NA, while learning how to address and resolve many of the issues specific to women seemed to come from "members of the tribe," which included women not only from AA and NA, as well as Al-Anon, but also from women with whom they shared common paths and experiences that allowed them to re-interpret their traumatic life experiences, such as childhood sexual abuse and victimization, into positive avenue for helping other women with similar experiences overcome *their* problems. This process helped the women develop self-worth and gave them hope, as well as meaning and purpose in life.

Beattie (2001) conducted a meta-analysis of the research that has been written regarding relationships, social support, and the structure and function of those relationships regarding the cessation or facilitation of drinking behavior. Overall, findings indicated social support to be the most important variable in the cessation of drinking behavior. Findings also indicated lack of support was an important variable in the facilitation of drinking behavior. Mohr, Averna, Kenny and Del Boca (2001) found the structure and quality of adult friendships to be an important component of drinking behavior. In the current study, the nature of relationships changed from externally-

focused associations developed during the course of the participants' addiction processes, shifting to those friendships based on internal similarities just prior to, and during, the recovery process. One of the most interesting features of "relationships" in the current study was the "changing face or nature" of these relationships over the course of development and eventually the unraveling of the addiction process. As previously mentioned, the addiction process involved violent and abusive relationships, first with immediate family members, and later with friends and partners. A few examples illustrated the *way* the relationships changed over time during the development and maintenance of addiction, but not enough to emerge from the data as an important theme per se. During the height of the participants' addiction, their friendships seemed to revolve those individuals with whom they shared similar alcohol or other drug use patterns (external factors); whereas, friendships developed in recovery seemed to be based on shared feelings and hope for recovery (internal factors). This might be an interesting study for future research. The primary findings in the current study were related to the specific experiences of trauma and violence, and the extreme negative impact these experiences had on the participants' development. The women primarily found the relationships they developed in recovery to be most important, possibly because they helped the women find not only a way to survive without drugs and alcohol, but a way to live happy and productive lives.

These behavior changes indicated the women were becoming responsible for their own lives. Twelve-step meetings were instrumental in the participants' recovery,

both as a vehicle for attaining abstinence, as well as providing a social network for meeting other individuals who share a common solution-oriented goal of recovery. Salmon, Joseph, Saylor, and Mann (1999) found that women in treatment thought the most helpful aspects of the treatment program to be providing coping mechanisms, 12-step programs and spiritual guidance. Learning to take action included 12-step meeting attendance, as well as individual therapy. Therapy designed to address and resolve victimization issues has been an integral part of the recovery process for many people (Kang, Magura, Laudet, & Whitney, 1999; Jarvis, Copeland, & Walton, 1998; Spak, Spak, & Allebeck, 1998; Chiavaroli, 1992; Henderson & Boyd, 1997; Goulding & Schwartz, 1995; Horney, 1992). The participants in current study spent, on the average, five years in therapy. In addition to therapy, the participants found sharing their stories with other women who could benefit from them to be instrumental in promoting the healing process. They found that their painful experiences could serve a useful purpose, giving new meaning that all was not for naught. The concept of the true or core "self" is described as the core of compassion and strength who is the true leader among multiple characters that co-exist within an individual (Goulding and Schwartz, 1995; Schwartz, 1995). Through connecting with others…they connected with their true "self."

THEME V. THE PROCESS OF BECOMING WHOLE

Theme V, the "process of becoming whole," was comprised of "members of the tribe", "principles for living" and "transforming moments." The process of becoming whole inherently implies brokenness. The current study found that relationships,

especially with other women, were indispensable in helping the participants recover from chemical dependency by providing them with a spiritual connection to another caring human being, and eventually leading to a connection with their own soul or spirituality.

Spirituality was an important component for the participants in the current study and seemed to begin with their connection to other members of the tribe. "The subjective experience of feeling consciously connected with others and our environment—to that which is larger than ourselves—has been found to promote physical and mental health, or well-being" (Andrews, 1996, p. 39). Interviews conducted with ten women in recovery from alcoholism revealed interpersonal processes/relationships and spirituality as important and predominant themes for women in recovery (Rankin, 2000) and DiLorenzo, Johnson, and Bussey (2001) also reported spirituality as one of the essential foundations for the remediation of an addictive disease.

The stories shared by the participants in the current study reminded me very much of the "tribe members" described by Gilda Radner, who, as a result of her experience with cancer, formed groups for individuals who had or have cancer, including their family and friends. Radner (1990) referred to these individuals as "Members of the Tribe." The purpose of these groups was to unite people who share a common problem, bringing them together to provide support and share their common experiences, as well as their common solutions.

Dean's (1996) findings, based on feminist theory and Jungian psychology of female psychopathology, found a meaningful process of transformation and

individuation important for recovery from alcoholism. This process involved both growth and healing of old wounds facilitated through talk and relationships with others and with a Transcendent other. The current study emulates these findings. The participants also experienced "transforming moments" they called miracles or spiritual awakenings, most often attributed to a "Higher Power" or God; they were touched by grace that was unexplainable and unequivocally real.

Lowery (1998) examined recovering American Indian women's personal stories of the addiction and recovery process. Four concepts (1) balance and wellness, (2) the colonization experience and addiction as a crisis of the spirit, (3) issues of abuse, including sexual abuse, and (4) a time of healing were presented. The women in the current study had experiences similar to those of the American Indian women regarding oppression and marginalization that reduce the quality of life to the survival level of existence. The participants in the current study were exposed to traumatic, abusive, and violent encounters experienced in an unchangeable and hostile environment, especially as children, followed by the subsequent development of chemical dependency that created a "crisis of the spirit," as represented by the participants' splintering or disconnection from the true self.

The "members of the tribe" served to heal the crisis of the spirit through sharing experience, strength and hope with women in the current study. They shared not only similar stories of abuse, but also their experiences of triumph, offering the participants comfort and hope in an atmosphere of acceptance that promotes healing and recovery

through a sense of connectedness and belonging. The women courageously examined their internal state of existence, acknowledging personal transforming moments, and sharing with others…that helped complete their individual processes for becoming…whole.

Kearney (1998) found by using grounded theory and the constant comparison method the basic process of recovery for women was truthful self-nurturing, which required a painful awareness shift in which addiction gained meaning as a problem. Subsequent recovery involved three areas of social-psychological change: abstinence work, self-work, and connection work. Benefits from these areas of work were increased self-understanding, self-acceptance, sense of belonging, and empowered connectedness. The women in the current study found abstinence work within the AA and NA 12-step framework of recovery. However, a surprising finding was that Al-Anon attendance (and the members) seemed to play a particularly important role in facilitating the participants' development of "self-care" and "self-reliance," in financial areas and especially with issues regarding guilt and shame surrounding their past behavior involving their relationships with their children.

"Recovery of the self" was facilitated through therapy and/or through connecting with these and other recovering women, the "members of the tribe." Goulding and Schwartz (1995) have developed a therapeutic model based on existing theories of multiplicity of the mind and a model of systems thinking, called Internal Family Systems (IFS) theory. This therapeutic model provides a framework that addresses and is

consistent with, the issues that emerged from the interviews of the participants regarding the addiction and recovery processes. Therefore, findings reported in the current study support Goulding and Schwartz' (1995) Internal Family Systems (IFS) theory in the development and maintenance of, as well as recovery from, addictive behaviors. Since therapy was an important component in helping the women in the current study deal with a variety of trauma and abuse issues, internal family systems therapy might prove to be a very effective model for facilitating the recovery process. Al-Anon members as well as other women also supported the recovery process by addressing trauma-related issues.

"The process of becoming whole" involved "members of the tribe" and their role in helping the participants develop principles for living. The women in these stories found a way to replace the adaptive responses and stop the cycles of abuse and violence. Many of the women, in the process of coming to terms with their own abusive situations, discovered that their abusive parent(s) had themselves been victimized. This realization for many of the women fostered the beginning of a healing process that culminated in forgiveness. Witvliet, Ludwig, and Vander Laan (2001) found that forgiving thoughts and responses were associated with greater perceived control and lower physiological stress responses thereby enhancing health. On the other hand, chronic unforgiving responses increased the stress response, thus eroding health. Therefore, forgiveness in the current study may have been a necessary component of healthy behaviors and may have functioned to facilitate recovery in this capacity.

Fortunately these women found a new way to live. As the women learned about living, a gut-level knowledge of reality set in and self-discovery began. The participants came to a place where they were faced with continuing on in their lives the best they could or learning to grow through pain without the use of chemicals. Many of them went to therapy. Interestingly, some went to therapy long before their chemical solutions quit working. This may have provided the women with the strength they subsequently needed to let go of destructive behavior patterns. The participants learned how to make healthier choices, often by simply being shown they had choices or alternatives to their present life circumstances. Trauma resolution seems to be a necessary component for recovery of the self. They found that working with others restored their self-confidence and kept them from self-pity. They learned how to become empowered through using the tools introduced to them through other recovering individuals who also attended meetings and served as positive role models.

The phenomena of the addiction and recovery process in the current study were grounded in and developed from the life stories of the participants' experiences that altered, gave meaning to, and shaped their lives. Hopefully, these definitions of phenomena from the participants' standpoint will help locate crises intervention points that may be utilized for implementation of programs, facilitate understanding to better inform policy and policy makers in dictating the future development of programs designed to address a number of areas that impact women's health.

Contextualization

Contextualization relocates the phenomenon (in this case, the addiction and recovery process) back in the natural world from the perspective of the participant. In other words, "How have individual biographies and the effects of epiphany experiences shaped these individuals and their social relationships?"

First and foremost, addiction is a *health* issue, not a criminal issue, and should be treated as such (Baer, Marlatt, & McMahon, 1993). One major area that impacts women's health in relation to the addiction and recovery process includes identification, prevention, intervention, and treatment of abuse and domestic violence. Better policies would invoke stiffer penalties for perpetrators of abuse and violence and decriminalize substance abuse regarding women and their born and unborn children. These policies would additionally hold the men equally responsible for their role in fathering born and unborn children. Recommendations for sentence reduction for non-violent drug related crimes, in combination with new and innovative programs designed to initiate and motivate behavior change, are necessary. This provision would make it possible for economically disadvantaged and otherwise oppressed women to receive an education and provide them with financial, emotional, physical and psychological support.

"America's War on Drugs" has become a term familiar to most individuals residing in the U.S. While implying action, this "war" ignores the most widely used drug: alcohol. It also ignores the underlying factors common to many addicted women. Sexual abuse and domestic violence during child- and adulthood were shared

experiences among the women who participated in the current study. Also, as previously mentioned, studies have shown that neurological structural and functional changes that occur as a result of exposure to traumatic experiences (Lewis, 1992) facilitate and exacerbate the subsequent development of chemical dependency problems, as well as depression and/or other disorders (Fishbein, 1998).

Therefore, future research is needed to determine: 1) if and what portion of chemical dependency, depression, and/or other mental illness may be attributed to neurological and structural changes that occur in the brain as a response to traumatic and abusive experiences, 2) if and what portion of this adaptive response to a hostile environment may be further enhanced and reinforced by the subsequent development of substance abuse, and 3) if and how would a genetic predisposition for addiction/alcoholism interact with these neurobiological adaptations? This information could lead to revolutionary changes in the treatment strategies developed for chemical dependency, depression, and/or other disorders. Additionally, prevention measures should include programs designed to reduce exposure to preventable traumatic events, like child abuse and domestic violence that are correlated with the subsequent development of chemical dependency and/or other disorders.

SEXUAL ABUSE

Since sexual abuse has been repeatedly shown to be a major risk factor contributing to the subsequent development of substance abuse, *chemical dependency* prevention and intervention programs would likely be more effective if they included

components that specifically addressed the prevention of, and intervention measures for, *sexual and physical abuse* (Hillis et al., 2001; Root, 1989). Prevention and intervention programs designed to raise public awareness of the long-term harmful effects associated with sexual and physical abuse and that provide more opportunities for girls (and boys) to escape from, or otherwise end, the abuse without humiliation or reprisals could be facilitated through a variety of mediums, but especially those that utilize modern advances in information and media technologies (Shulman, Shapira, & Hirshfield, 2000).

Programs designed to provide a variety of effective coping skills and strategies for chemically dependent women is another way to drastically reduce addictive behaviors. Previous researchers, as well as the current study, have found that alcohol use, when utilized as a coping mechanism, often becomes a vicious cycle. The more an individual drinks to cope, the less s/he is likely to acquire and practice using effective coping techniques, which in turn contribute to the addictive process in an effort to avoid dealing with the underlying problems (Holahan et al., 2001). Generalized efforts to increase the self-esteem of women and their ability to act independently of male partners would also be useful in preventing the development of substance abuse problems in women.

The reduction of female stereotypes of all kinds is necessary, but particularly important is the need to promote the concept of substance abuse as a health issue, rather than a moral issue (Morell, 1996). Women are still "demonized" for their drug use and therefore portrayed as inhumane and unworthy of civil rights or rehabilitative services.

Programs that challenge these stereotypes and that can facilitate a paradigm shift that promotes empathetic understanding of addiction through innovative strategies that demonstrate the link between abuse, violence and the utilization of chemical dependency as an adaptive survival response are necessary to bring about true change in the attitudes of the political bodies that govern and make policy (Coid et al., 2001).

ABUSE AND DOMESTIC VIOLENCE

The next best thing to prevention is early detection and treatment. The following paragraphs contain suggestions for intervention strategies for abuse and domestic violence. More research is needed to determine causes and effective solutions for the perpetrators of abuse and domestic violence, particularly regarding family of origin victimization issues. Perpetrator and batterer intervention programs that target offenders, especially repeat offenders, in every state, that work in conjunction with the criminal justice system are an urgent need (Coid et al., 2001). Alternative tools such as medication, behavioral modification strategies that target anger management, financial planning, problem-solving and parenting skills need to be integrated and incorporated into comprehensive intervention and treatment programs (Morell, 1996). Involvement in these programs for offenders could be made mandatory by requiring participation in an ongoing program that is contingent on the perpetrator's release. Funding for these types of programs could be a cost-effective investment for insurance companies that underwrite emergency room visits for victims of abuse and/or domestic violence.

Stronger legislative laws for repeat offenders, as well as allowing the courts more flexibility in issuing restraining orders, and requirements dictating felony prosecution after two abuse or violence convictions are desperately needed. Insurance or other private sectors are needed to fund programs to help ease the financial burden of spouses who are imprisoned for abuse and/or domestic violence, as well as to help the victims establish a firm economic base that would enable them to leave an abusive relationship.

Domestic violence is closely associated with alcohol and drug use and abuse, as well as and facilitating re-victimization of women. Therefore, women who are trapped in "vicious cycles" are more likely to become involved in, and therefore are disproportionately affected by these abusive relationships. All of the women in the current study were victims of domestic violence. Brown and Williams (1989) found that women charged in the death of a mate have the least extensive criminal records of any people convicted. However, they often face higher penalties than men who kill their partners. FBI statistics indicate that fewer men are charged with first- or second- degree murder for killing a woman they have known than are women who kill a man they have known. Women convicted of these killings are frequently sentenced to longer prison terms than are men. The average prison sentence of men who kill their women partners is 2 to 6 years. Women who kill their partners are sentenced on average to 15 years, despite the fact that most women who kill do so in self-defense (Jurik & Winn, 1990). Therefore, a re-evaluation of past and current laws and cases in which women are

sentenced to longer jail sentences than their male counterparts is another necessary and vital agenda component.

Individual interventions for the victims of domestic violence that support self-defense, build self-esteem, educate and offer medical services, that promote healthy interaction skills, and that identify faulty logic in the reasoning skills of their violent partner only scratch the surface of this deeply-rooted problem. Intervention programs need to be instituted not just at the individual, but multiple levels. Currently, medical providers have been identified as the least effective professional source for help. Since it is up to the medical community to become more aware of the problem of family violence and be willing to ask about it (Varvaro, 1998), community-based programs instituted to educate and raise awareness of the signs of domestic violence, as well as programs designed to better educate members of the medical community, including private physicians and those who work in conjunction with county agencies, and to provide resource information upon problem identification would be of great benefit.

Unfortunately, dealing with substance-abusing women as a group is not as easy as dealing with some other groups, because these women are not ideal victims. Often, a history of substance abuse precludes them from qualifying for disability, welfare benefits, and even battered women's shelters at possibly the most critical time of their, and their children's, lives (Goldberg, 1995).

Additionally, participation in residential treatment programs is difficult for women with dependent children because no wide-scale provisions for children are

available to accommodate mothers who need treatment. Goldberg (1995) reports that only a few experimental treatment programs provide accommodation for children with their mothers. Mothers receiving public assistance may lose their income if they go into treatment and leave the children with someone else. After treatment, they may be unable to get the benefits back without the children and unable to take the children back without the benefits. When a child is placed in a foster home by the state for the duration of the mother's treatment, getting the child back after her treatment has been completed often becomes a difficult or impossible task (Goldberg, 1995). Therefore, compared to the fathers of these children, single mothers, who have the sole responsibility of caring for their children, and who need or want treatment are disproportionately disadvantaged by *being* responsible for their children.

Criminalization of substance abuse during pregnancy also interferes with women who need or want treatment. This represents a new level of legal interference with women's rights over their bodies, interference that, like abortion, has no male counterpart (Goldberg, 1995; Maher, 1990). Future research and innovative programming are necessary in order to provide alternatives for this conundrum.

Treatment success depends on many social and personal factors. Affordable, accessible, visible, and accommodating services for women with dependent children must be developed and implemented. These programs must address the problems of the individual and her children, such as victimization issues like sexual abuse and domestic violence. These are important issues that must be addressed at all levels during and after

formal treatment. Specific crises that precipitate, contribute to, or exacerbate problematic alcohol/drug usage must be given proper attention. Grief counseling, parenting issues, co-morbid disorders (such as depression or PTSD) are only a few of the issues that must be simultaneously diagnosed and treated if successful outcomes are to be attained (Eastland, 1995).

Eye movement desensitization and reprocessing (EMDR), is a clinical treatment that has successfully helped individuals who have survived trauma, including sexual abuse, domestic violence, combat, crime, and those suffering from a number of other complaints including depression, addiction, phobias, and self-esteem issues. Edmond, Rubin, and Wambach (1999) found between two groups in equal number of sessions of individual EMDR treatment and routine individual treatment sessions significantly reduced the symptoms of anxiety, posttraumatic stress, and depression. However, treatment gains were sustained by the EMDR participants, but not by participants in the individual treatment sessions at three-month follow-up. This seems to be a promising avenue for future research exploration.

OPPRESSION

The women in the current study were raised amidst abuse and violence - oppressive conditions with little hope, control, or power for change or even to make decisions. The conditions contribute to unhealthy addictive and destructive behaviors, and can lead to death. A classic experiment in physiology is to yoke two mice together so that only one is free to eat, sleep, walk around, and engage in activity, while the other

is passively dragged along. In short order the two will look remarkably different; the animal who has freedom of choice will continue to be robust and healthy, while the one who suffers loss of autonomy will be apathetic, disease prone, and old before its time. The dragged-along mouse has suffered no physical abuse, but losing its freedom of choice is stressful enough to trigger massive destructive reactions in the body. Laboratory animals can be induced to develop practically any disease, or to advance its course more rapidly. Overcrowding produces depressed immune systems, hypertension, neurosis, apathy, and depression. Baby monkeys, who have been separated from their mothers at birth and deprived of nurturing, exhibit disorientation, hyperactivity, introversion, and various learning disabilities (Chopra, 1993; Mason & Berkson, 1975).

Simone de Beauvoir (1989) describes adolescence as the beginning of a struggle for self-definition in a world that defines women's primary identity as a passive object of male attention. While most of the participants in the current study grew up a little later than de Beauvoir, Pipher (1994) describes girls in America *today* as being even *more* oppressed, as coming of age in a more dangerous, saturated culture that limits their development, truncates their wholeness, and leaves many of them traumatized. Miller (1986) says, "Humanity has been held to a limited and distorted view of itself – from its interpretation of the most intimate of personal emotions to its grandest vision of human possibilities – precisely by virtue of its subordination of women" (p. 2). In reality, gender biased stereotypes profoundly affect our sense of who we are and who we can become (Heilman, 1998).

The most basic difference, although not always clear, is the factor of inequality between men and women. There are inequalities of many kinds of resources, but fundamentally of status and power (Miller, 1986). Subordinates (in this case women) are usually said to be unable to perform the preferred roles. Their incapacities are ascribed to innate defects or deficiencies of mind or body, therefore immutable and impossible to change or develop. More importantly, the subordinates themselves can come to find it difficult to believe in their own abilities (Miller, 1986).

"Humanity has been held to a limited and distorted view of itself – from its interpretation of the most intimate of personal emotions to its grandest visions of human possibilities – precisely by virtue of its subordination of women. Until recently, 'mankind's' understandings have been the only understandings generally available to us. As other perceptions arise, precisely those perceptions that men, because of their dominant position, could NOT perceive – the total vision of human possibilities enlarges and is transformed. The old is severely challenged" (Miller, 1986, p. 2). Therefore, as the subordination of women becomes increasingly unacceptable, women's voices will be heard. They will lend a different perspective to understanding problems experienced by women in which the victim is blamed, thus exposing to the world the larger picture of cultural bias and oppression that supports the structure of internal invalidation. Awareness and wisdom will be brought into focus, severely challenging conventional reality.

FEMINIST CONCERNS REGARDING 12-STEP PROGRAM PHILOSOPHY

As mentioned in Chapter 2, 12-step programs are saturated with male-oriented language. This language defines, limits, and labels God as male. This may be, perhaps, an unconscious delegation of masculine characteristics to a super-natural being, as well as indicative of the historical time period during which the literature was written, compounded by the limiting constraints of the English language.

In addition to referring to God as "He" or "Him", the text is directed specifically to the male alcoholic, with one chapter dedicated and titled "To the wives." However, Covington (1994) says "rather than rewrite the Steps in a way that attempts to fit all women, we can instead work with the original Steps - paying close attention to the spirit and meaning - and reinterpret the language to support our own recovery…The program defies the language…there's something powerful and healing concealed beneath the archaic wording….and reframe the original wording in the way that works best for us, each of us, individually, can discover the meaning for ourselves" (p. 5). This may provide an alternative solution that is acceptable to some women, but certainly does not address feminist criticisms of the marginalization of women inherent in the male - dominated language of 12-step programs that supports and facilitates male-superiority.

Another of the feminist criticisms leveled against 12-step programs concerned the "disease" concept of alcoholism and other drug addiction. Horney argued, "inner conflict is the avoidable consequence of the contradictions and dehumanizing elements of civilization as transmitted by parents to their children. The neurotic shares the same

cultural context as the non-neurotic but experiences its effects more intensely. In this respect neurotic conflict is simply an extreme version of the psychological conflicts that are typical in a given culture, and the neurotic individual is that culture's prototype. Neurotic suffering reflects critically on the cultural context to which it is a response…the neurotic is a victim whose suffering is not an individual failure but the rational human response to a culture that is sick" (Westcott, 1986, p. 12-13; Horney, 1992, 1991, 1964). This description of the neurotic depicts the internal conflict developed and experienced by the women in the present study; and therefore, reflects the symptoms of a sick culture rather than an individual disease. Although 12-step programs may benefit individuals who identify with "mainstream AA" members and their philosophies, it does nothing to address the social problems identified and associated with cultural ills, like oppression, that contribute to the development of chemical dependency problems.

AA and other 12-step oriented programs have been accused of fostering dependence through their approach to addiction as a "disease" over which the individual is considered to be powerless; and that acceptance of this powerlessness is the only route to recovery. Horton (2001) states that every decrease in power is an open invitation to violence, and that the antithesis of violence is not peace, but power. Saulnier (1995) states, "To summarize, the notion of powerlessness which is promoted in twelve-step programs may be a serious hindrance for marginalized people, particularly women. Its flexibility in addressing the specific needs of members of outgroups is, at best, uncertain. Added to the notion of addiction, in which everyday life is pathologized and

sociopolitical circumstances are individualized, the twelve-step/addiction philosophy provides a questionable approach for intervention with people who are in need of social justice" (p. 101). However, the possibility exists, as demonstrated by the women in the current study, that this approach lends positive value by defining a path to recovery based on individual responsibility *in spite* of social injustice; not necessarily to the exclusion that social change is not considered essential. This serves to eliminate self-pity while promoting recovery and better equipping the individual to recognize, initiate, and promote these changes so that others may develop alternative approaches in order for others whom, as of yet, recovery has not become a viable option or for whom the framework has been ineffective.

The feminist concern that 12-step programs foster group dependency (Vick et al., 1998) was not evident in any of the participants' experiences. Rather than dependence, the group members seemed to be an important source for gaining knowledge and information about the recovery process. The women in particular seemed to play the most important role in the "recovery and reconnection of the self in the process of becoming whole" and therefore viewed as a vital source of social support.

Dyer (1992) describes and synthesizes a framework consisting of three types of consciousness. One is The Individual, one is The Group, and the third is called Siddha. The Individual consciousness is ego-based and centers on the external, how much an individual has or does, as well as what other people think; much like the women at the

height of the addiction process. This type of consciousness increases competition between and therefore serves to separate individuals.

Group consciousness is described as identification with a group or groups that is/are part of one's life, like "Jewish," "Catholic," "African-American," or "Caucasian" to name a few. Other examples include groups in school such "Preppies" or "potheads." This type of consciousness has the capacity to promote prejudice and hatred and to incite riot or war (Dyer, 1992). Alcoholics Anonymous resembles this form of consciousness regarding their approach that excludes "drug addicts" from participating in meetings with "alcoholics." The intent behind the action is to prevent the dilution of the message of recovery; however they are not completely immune to the suffering of others, hence lending the 12 steps for adaptation to groups for problems other than alcohol.

The third type is Siddha, which means the ability to transcend form, to ask, "What is real?" That which never changes is real. The relationships that the participants formed with other women who had walked a similar path provided the women in the current study with models of similar past experiences and a variety of effective strategies, and a safe haven free of guilt and shame within which to reflect, examine and reconnect with their true selves. These "connections" with others promote healing and thus facilitate the reunification of the "true self." In this manner, these connections – with others and within the self - together they establish a union that transcends form. The participants in the current study became empowered through their process of becoming whole, evidenced as they engagingly told their personal stories of trauma,

addiction, recovery, and transcendence. We truly must join together to provide the opportunity to develop Siddha or transcendence for ourselves and for our children, but most of all for the women and children who have no power and no voice – so that they, too, have the opportunity to seek and find, that which is real…that which never changes.

Appendix A: Interview Guide

1. Demographic information:

   First name

   Race

   DOB

   Place of Birth

2. Can you describe your childhood for me? (What was your family like? How many brothers and sisters did you have?)
3. Can you give me a detailed account of a typical day in your life when you were growing up?
4. Can you tell me about any experiences that really stand out in your mind-good or bad - that changed your life forever.
5. What factors do you feel were the biggest influence in leading to your substance abuse?
6. Can you give me a detailed account of a typical day in your life when you were using?
7. What do you feel were the major obstacles that you had to overcome to obtain treatment/recovery?
8. What helped you the most in your early recovery?

9. What were some of the toughest issues you had to deal with? How or where did you learn the skills to cope or deal with these issues?
10. Can you give me an account of a typical day in early recovery?
11. What helps you the most now?
12. What is the most difficult thing you have had to face in recovery and how did you get through it?
13. What would you say are the biggest issues in your life today?
14. What have your relationships with significant others and/or family members been like?
15. Can you give me an account of a typical day in your life now?
16. How would you define addiction? recovery?

Appendix B: Modified Interview Guide

1. Demographic information:
   First name
   Race
   DOB
   Place of Birth
2. Can you describe your childhood for me? For example, what was your family like; brothers or sisters, etc?
3. Can you tell me about any experiences that really stand out in your mind - good or bad - that changed your life forever?
4. Can you tell me about the process that led you to use alcohol or other drugs?
5. Can you tell me about your experiences during that time?
6. What happened that made you think that you might need help?
7. What were some of the toughest issues you had to deal with in early recovery?
8. How did you cope or deal with these issues?
9. What is the most difficult thing you have had to face in recovery?
10. How did you get through it?
11. What would you say are the biggest issues in your life today?
12. What are your relationships with significant others and/or family members like today?

Appendix C: AA Information

THE FELLOWSHIP OF AA

If the newcomer is satisfied that he or she is an alcoholic and that AA may be able to help, then a number of specific questions about the nature, structure, and history of the movement itself usually come up. Here are some of the most common ones.

What is Alcoholics Anonymous?

There are two practical ways to describe AA The first is the familiar description of purposes and objectives that appears earlier:

"Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics achieve sobriety."

The second way to describe AA is to outline the structure of the Society. Numerically, AA consists of more than 2,000,000 men and women, in 150 countries.

These people meet in local groups that range in size from a handful of ex-drinkers in some localities to many hundreds in larger communities.

The local group is the core of the AA Fellowship. Its open meetings welcome alcoholics and their families in an atmosphere of friendliness and helpfulness. There are now more than 97,000 groups throughout the world, including hundreds in hospitals, prisons, and other institutions.

Are there many women alcoholics in AA?

The number of women who are finding help in AA for their drinking problem increases daily. Approximately one-third of present-day members are women; among newcomers, the proportion has been rising steadily. Like the men in the Fellowship, they represent every conceivable social background and pattern of drinking.

The general feeling seems to be that a woman alcoholic faces special problems. Because society has tended to apply different standards to the behavior of women, some women may feel that a greater stigma is attached to their uncontrolled use of alcohol.

AA makes no distinctions of this type. Whatever her age, social standing, financial status, or education, the woman alcoholic, like her male counterpart, can find understanding and help in AA Within the local group setup, women AA members play the same significant roles that men do.

ALCOHOLISM AND ALCOHOLICS

Not too long ago, alcoholism was viewed as a moral problem. Today, many regard it primarily as a health problem. To each problem drinker, it will always remain an intensely personal matter. Alcoholics who approach AA frequently ask questions that apply to their own experience, their own fears, and their own hopes for a better way of life.

Alcoholism

There are many different ideas about what alcoholism really is. The explanation that seems to make sense to most AA members is that alcoholism is an illness, a *progressive* illness, which can never be cured but which, like some other diseases, *can* be arrested. Going one step further, many AAs feel that the illness represents the combination of a physical sensitivity to alcohol and a mental obsession with drinking, which, regardless of consequences, cannot be broken by willpower alone.

Before they are exposed to AA, many alcoholics who are unable to stop drinking think of themselves as morally weak or, possibly, mentally unbalanced. The AA concept is that alcoholics are sick people who can recover if they will follow a simple program that has proved successful for more than one and a half million men and women.

Once alcoholism has set in, there is nothing morally wrong about being ill. At this stage, free will is not involved, because the sufferer has lost the power of choice over alcohol. The important thing is to face the facts of one's illness and to take advantage of

the help that is available. There must also be a desire to get well. Experience shows that the AA program will work for all alcoholics who are sincere in their efforts to stop drinking; it usually will not work for those not absolutely certain that they want to stop.

The Recovery Program

Upon attending only a few meetings, the newcomer is sure to hear references to such things as "the Twelve Steps, "the Twelve Traditions, " "slips, " "the Big Book, and other expressions characteristic of AA The following Paragraphs describe these factors and suggest why they are mentioned frequently by AA speakers.

What are the "Twelve Steps"?

The "Twelve Steps" are the core of the AA program of personal recovery from alcoholism. They are not abstract theories; they are based on the trial-and-error experience of early members of AA They describe the attitudes and activities that these early members believe were important in helping them to achieve sobriety. Acceptance of the "Twelve Steps" is not mandatory in any sense.

Experience suggests, however, that members who make an earnest effort to follow these Steps and to apply them in daily living seem to get far more out of AA than do those members who seem to regard the Steps casually. It has been said that it is virtually impossible to follow all the Steps literally, day in and day out. While this may be true, in the sense that the Twelve Steps represent an approach to living that is totally

new for most alcoholics, many AA members feel that the Steps are a practical necessity if they are to maintain their sobriety.

Here is the text of the Twelve Steps, which first appeared in *Alcoholics Anonymous*, the AA book of experience:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our short-comings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

What are the "Twelve Traditions"?

The "Twelve Traditions" of AA are suggested principles to insure the survival and growth of the thousands of groups that make up the Fellowship. They are based on the experience of the groups themselves during the critical early years of the movement.

The Traditions are important to both oldtimers and newcomers as reminders of the true foundations of AA as a society of men and women whose primary concern is to maintain their own sobriety and help others to achieve sobriety:

1. Our common welfare should come first; personal recovery depends upon AA unity.

2. For our group purpose there is but one ultimate authority — a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

3. The only requirement for AA membership is a desire to stop drinking.

4. Each group should be autonomous except in matters affecting other groups or AA as a whole.

5. Each group has but one primary purpose — to carry its message to the alcoholic who still suffers.

6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.

7. Every AA group ought to be fully self-supporting, declining outside contributions.

8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.

9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.

12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

CONCLUSION

The primary purpose of AA is to carry our message of recovery to the alcoholic seeking help. Almost every alcoholism treatment tries to help the alcoholic maintain sobriety. Regardless of the road we follow, we all head for the same destination,

recovery of the alcoholic person. Together, we can do what none of us could accomplish alone.

We can serve as a source of personal experience and be an ongoing support system for recovering alcoholics.

Other Twelfth-Step Programs Look at AA

Dozens of self-help programs flourishing today borrow from AA's Steps, Traditions and Concepts—just as AA itself came about through the experience and wisdom of others, including various religions and the Oxford Group. One such is Narcotics Anonymous, founded in 1953, which lists thousands of groups worldwide. Some years ago, in their newsletter *Newsline*, NA's trustees shared "Some Thoughts on Our Relationship to AA"

"NA," the trustees stated, "is modeled after, though not identical to AA Nearly every NA group in existence has leaned to some degree on AA in its formative stages. Our relationship with that Fellowship over the years has been very real and dynamic." The trustees noted that "one of AA's greatest strengths is its single-minded focus on one thing only: By limiting its primary purpose to carrying the message to alcoholics, avoiding all other activities, AA is able to do that one thing supremely well. . . .

"From early on, AA was confronted by a perplexing problem: 'What do we do with drug addicts? They come in here talking about drugs, inadvertently weakening our atmosphere of identification.' The Steps were written, the Big Book was written—were

they supposed to rewrite it all? Allow identification to blur so that no one acquired a clear sense of belonging? Kick these dying people back into the street?" In the end, the NA trustees noted, "AA said that while they cannot accept nonalcoholic addicts as members, they freely offer their Steps and Traditions for adaptation by any groups who wish to use them. They pledged their support in a spirit of 'cooperation, not affiliation.' This farsighted solution to a difficult problem paved the way for the development of the NA fellowship."

Another fast-growing self-help organization that views AA as its model is Cocaine Anonymous (C.A.), now nearing its 20th anniversary. Reflecting on C.A.'s "excellent relationship" with AA, past C.A. world service trustee Jennifer R., of Costa Rica, explained, "In C.A. our common identification is expressed in Step One: 'We admitted we were powerless over cocaine and all other mind-altering substances—that our lives had become unmanageable.' Even as we look to AA for guidance, we are separate, because each fellowship has a unique primary purpose. Each time someone recovers—whether from alcoholism in AA or from mind-altering substances in C.A.—we are helping each other."

Appendix D: N. A. Information

FACTS ABOUT NARCOTICS ANONYMOUS

A Society of Recovering Drug Addicts

Narcotics Anonymous is an international, community-based association of recovering drug addicts. Started in 1947, the NA movement is one of the world's oldest and largest of its type, with nearly twenty thousand weekly meetings in seventy countries. Here we hope to explain what Narcotics Anonymous is and what its recovery program offers to drug addicts. We will describe how NA services are organized at the local, national, and international levels. We will talk about how Narcotics Anonymous cooperates with others concerned about drug abuse in their countries and communities. Finally, we will provide information on NA's membership and indicators of the success of Narcotics Anonymous.

Development

Narcotics Anonymous sprang from the AA movement in the late 1940s, with meetings first sprouting up in the Los Angeles area of California, USA, in the early Fifties. For many years the society grew very slowly, spreading from Los Angeles to other major North American cities and Australia in the early 1970s. An assembly of local delegates was first established in 1978. In 1983 Narcotics Anonymous published its self-titled basic text, and growth rates have since skyrocketed. Groups formed rapidly in

Brazil, Colombia, Germany, India, the Irish Republic, Japan, New Zealand, and the United Kingdom. In the three years following initial publication of NA's basic text, the number of Narcotics Anonymous groups nearly tripled. Today, Narcotics Anonymous is fairly well established throughout much of Western Europe, the Americas, Australia, and New Zealand, with newly formed groups and NA communities scattered through the Indian subcontinent, Africa, East Asia, the Middle East, and Eastern Europe.

Program

NA's earliest self-titled pamphlet, known among members as "the White Booklet," describes Narcotics Anonymous as "a nonprofit fellowship or society of men and women for whom drugs had become a major problem . . . recovering addicts who meet regularly to help each other stay clean." Membership is open to any drug addict, regardless of the particular drug or combination of drugs used. There are no social-, religious-, economic-, racial-, ethnic-, national-, gender-, or class-status membership restrictions. Narcotics Anonymous membership is completely voluntary; no membership rolls or attendance records are kept, either for NA or anyone else. Members live in the community and attend meetings on their own time. There are no dues or fees for membership; most members regularly contribute small sums to help cover expenses at group meetings, but contributions are not mandatory.

The core of the Narcotics Anonymous recovery program is a series of personal activities known as the Twelve Steps, adapted from AA. These "steps" include admitting there is a problem, seeking help, self-appraisal, confidential self-disclosure, making

amends where harm has been done, and working with other drug addicts who want to recover. Central to the program is an emphasis on what is referred to as a "spiritual awakening," emphasizing its practical value, not its philosophical or metaphysical import, which has posed very little difficulty in translating the program across cultural boundaries. Narcotics Anonymous itself is nonreligious and encourages each member to cultivate an individual understanding, religious or not, of this "spiritual awakening."

Narcotics Anonymous believes that one of the keys to its success is the therapeutic value of addicts working with other addicts. In meetings, each member shares personal experience with others seeking help, not as professionals but simply as people who have been there themselves and have found a solution. Narcotics Anonymous has no professional therapists, no residential facilities, and no clinics. NA provides no vocational, legal, financial, psychiatric, or medical services. The closest thing to an "NA counselor" is the sponsor, an experienced member who gives informal assistance to a newer member.

The primary service provided by Narcotics Anonymous is the NA group meeting. Each group runs itself on the basis of principles common to the entire organization, principles laid out in the movement's literature. There is no hierarchical authority structure in Narcotics Anonymous. Most groups have no permanent facilities of their own, instead renting space for their weekly meetings in buildings run by public, religious, or civic organizations. Meetings may be "open," meaning anyone may attend, or "closed," meaning only people who are there to address their own drug problem may

attend. Meetings are led by NA members; other members take part by talking in turn about their experiences in recovering from drug addiction.

The Narcotics Anonymous program uses a very simple, experience-oriented disease concept of addiction. Narcotics Anonymous does not qualify its use of the term "disease" in any medical or specialized therapeutic sense, nor does NA make any attempt to persuade others of the correctness of its view. The NA movement asserts only that its members have found acceptance of addiction as a disease to be effective in helping them come to terms with their condition.

Narcotics Anonymous encourages its members to observe complete abstinence from all drugs, including alcohol, even substances other than the individual's drug of choice, though NA's only stated membership requirement is "a desire to stop using" drugs. It has been the NA members' experience that complete and continuous abstinence provides the best foundation for recovery and personal growth. However, Narcotics Anonymous takes no absolute stand as a society on the use of caffeine, nicotine, or sugar. Similarly, the use of prescribed medication for the treatment of specific medical or psychiatric conditions is neither encouraged nor prohibited by NA. While recognizing numerous questions in these areas, Narcotics Anonymous feels that they are matters of personal decision and encourages its members to consult their own experience, the experience of other members, and qualified health professionals in making up their minds about these subjects.

One more thing needs to be said about the Narcotics Anonymous program. Its members recognize that NA is but one organization among many addressing the problem of drug addiction. Members feel they have had significant success in addressing their own addiction problems, but Narcotics Anonymous does not claim to have a program that will work for all addicts under all circumstances or that its therapeutic views should be universally adopted. If Narcotics Anonymous can be useful to addicts in your care or in your community, it stands ready to be of service.

MEMBERSHIP DEMOGRAPHICS

No comprehensive surveys of Narcotics Anonymous membership have been completed to date, due especially to NA's emphasis on protecting the anonymity of the members. However, it is possible to offer some general, informal observations about the nature of the membership and the effectiveness of the program, observations believed to be reasonably accurate.

Male/female ratio

Of the 5,000 NA members responding to an informal poll taken in 1989:

- 64% were male
- 36% were female.

Socioeconomic background

The socioeconomic strata represented by the NA membership varies from country to country. Most national movements are founded by members of one particular

social or economic class, but as their outreach to the entire range of the drug- addicted population in each country becomes more effective, the membership becomes more broadly representative of all socioeconomic backgrounds.

Age

Of the 5,000 NA members responding to an informal poll taken in 1989:

- 11% were under 20
- 37% were between 20 and 30
- 48% were between 30 and 45
- 4% were over 45

Religious backgrounds

All religious backgrounds are represented among NA members. In a given national movement, the membership generally reflects the diversity or homogeneity of the background culture.

Rate of growth

Because no attendance records are kept, it is impossible even to estimate what percentage of those who come to Narcotics Anonymous ultimately achieve long-term abstinence. The only sure indicator of the program's success is the rapid growth in the number of registered Narcotics Anonymous meetings in recent decades and the rapid spread of Narcotics Anonymous outside North America. In 1978, there were fewer than 200 registered groups in three countries. In 1983, more than a dozen countries had 2,966

meetings. In 1994, we knew of groups holding 19,822 weekly meetings in seventy countries.

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Appendix E: Subject Consent Form

The University of Texas at Austin
Department of Kinesiology and Health Education

A Qualitative Analysis
of the Epiphany Experiences
of Chemically Dependent Women in Recovery

You are invited to participate in a study of restorative strategies developed and utilized by women who have demonstrated successful, ongoing recovery. My name is Kelly Stokely-Woodruff and I am presently a doctoral candidate at The University of Texas at Austin, in the Department of Kinesiology and Health Education. This is my dissertation project, which is a partial requirement for earning a Ph.D. in Health Education. I hope to learn how women develop salient coping strategies that promote and maintain abstinence. You have been selected as a possible participant in this study because I feel you have valuable insight to contribute to this problem based on your personal experience and success with recovery. You will be one of several women chosen to participate in this study.

If you decide to participate, I will interview you at your convenience and location choice. This will be a life history interview that will take approximately 1.5-2 hours and will be audio taped. The tapes will be coded so no identifying information is visible. The cassettes will be kept in a locked filing cabinet and will be transcribed using only the code names. No original names or personally identifying information will appear on the transcriptions. Tapes will be erased after the transcriptions are made. If necessary, a second interview may be scheduled (with your approval) if additional information is required.

The discomforts associated with participating in this project are: feeling uncomfortable recalling painful memories; possible embarrassment revealing personal information; or fear of being judged for past actions. The benefits for participating in this interview may be: the validation of feelings; a sense of empowerment developed from the active contribution of valuable information that be obtained only through personal experience. We hope the collective experiences illuminated in this project will result in better treatment strategies for women seeking recovery.

Any information obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission.

Subject Consent Form (cont.)

Your decision whether or not to participate will not affect your future relations with The University of Texas at Austin. If you decide to participate, you are free to discontinue participation at any time.

There is no cost to you for participating in this study, nor will there be compensation for individual participation.

If you have any questions, please ask me. If you later have any additional questions, my supervising professors, Mary Steinhardt or Alexandra Loukas, or I will be happy to answer them. I may be reached at home (830) 896-8607; Drs. Steinhardt and Loukas may be reached at (512) 232-3535 or (512) 232-9388, respectively.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time after signing this form, should you choose to discontinue participation in this study.

You may keep a copy of this form.

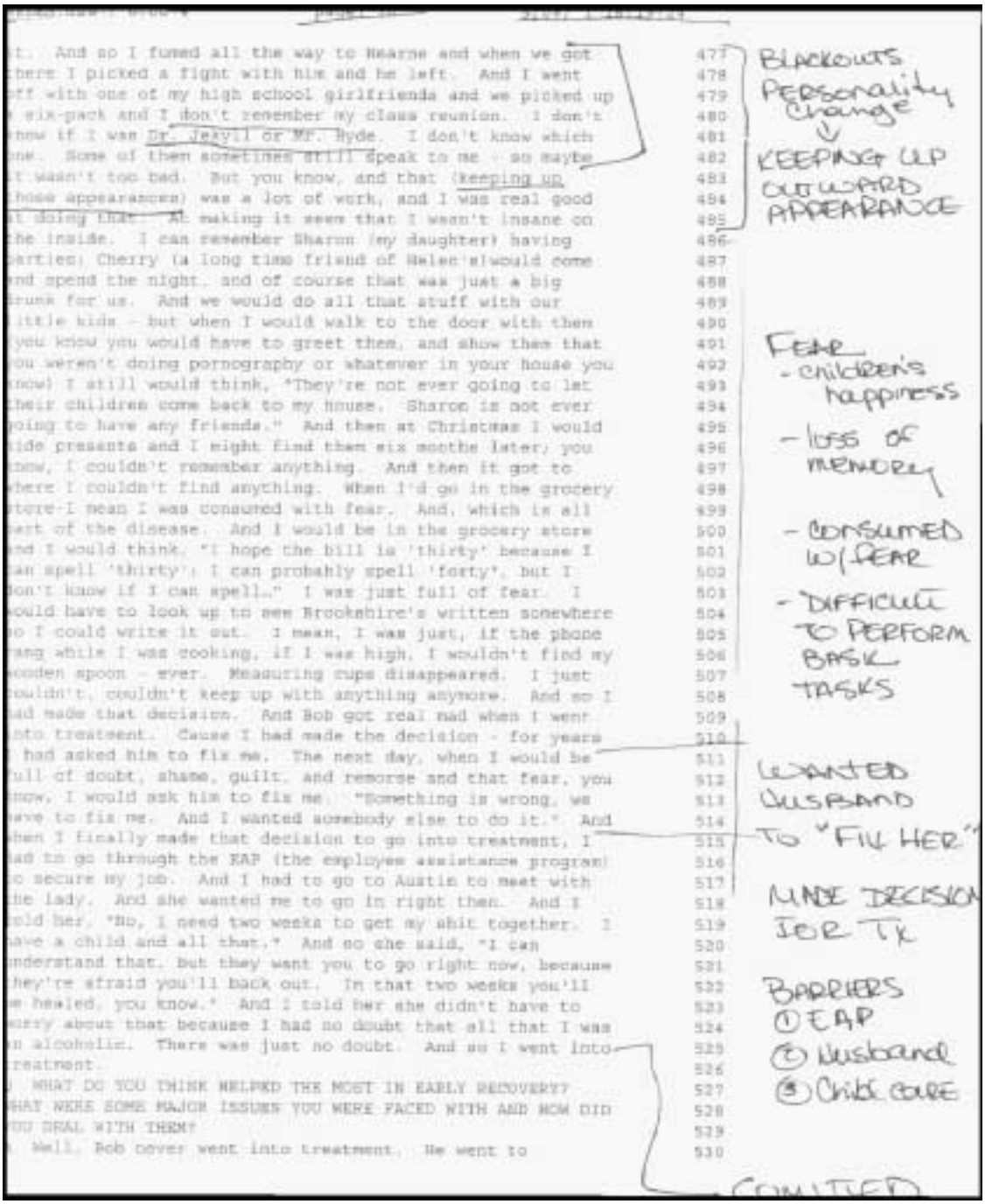
_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

Appendix F: Sample of First Level Coding



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